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In the Supreme Court of the United States

October Term, 1980

BLUE SHIELD OF VIRGINIA

and

BLUE SHIELD OF SOUTHWESTERN VIRGINIA,
Petitioners,

vs.

VIRGINIA ACADEMY OF CLINICAL PSYCHOLOGISTS

and

ROBERT J. RESNICK,
Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the independent decisions of the Petitioners to expand the coverage under their contracts with subscribers to include treatment by a psychologist where the psychologist's bill is submitted for payment by a physician fall outside "the business of insurance" for purposes of the McCarran-Ferguson Act?[1]

2. Whether the Petitioners are inherent "contract[s], combination[s] . . . or conspirac[ies]" of participating physicians within the meaning of § 1 of the Sherman Act where the physicians have no actual control over the day-to-day activities of the Petitioners and where the expansion of coverage to include psychologists was directly contrary to the physicians' economic interests?

3. Whether concerted action taken openly and in good faith to provoke a judicial resolution of the constitutionality of a Virginia statute (which was later held unconstitutional by the Virginia Supreme Court) lacks First Amendment protection under the *Noerr-Pennington* doctrine?

PARTIES

Blue Shield of Virginia;

Blue Shield of Southwestern Virginia;

Neuropsychiatric Society of Virginia, Inc.;

Virginia Academy of Clinical Psychologists;

and

Robert J. Resnick.

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1. 15 U.S.C. §§ 1011 to 1015.

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ROBERT J. RESNICK,
Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

Blue Shield of Virginia (the "Richmond Plan") and Blue Shield of Southwestern Virginia (the "Roanoke Plan") respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit in this case.[2]

2. The Richmond Plan and the Roanoke Plan were appellees below. Neither of the Plans has any parent, subsidiary or affiliated company other than wholly-owned subsidiaries. The Plans believe that the third appellee below, the Neuropsychiatric Society of Virginia, Inc., has no interest in the outcome of this petition under Rule 19.6 of the Rules of the Supreme Court.

OPINIONS BELOW

The opinion of the United States District Court for the Eastern District of Virginia, attached to this Petition as Appendix A, is reported at 469 F. Supp. 552 (E.D. Va. 1979). The opinion of the United States Court of Appeals for the Fourth Circuit, attached as Appendix B, is reported at 624 F.2d 476 (4th Cir. 1980).

JURISDICTION

The judgment of the Fourth Circuit was entered on June 16, 1980. Timely Petitions for Rehearing and Suggestions for Rehearing En Banc were denied on September 9, 1980. The Order of the Fourth Circuit denying the petitions is attached as Appendix C. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. § 1; sections 2 and 3(b) of the McCarran-Ferguson Act, 15 U.S.C. §§ 1012 and 1013(b); and sections 38.1-347.1, -360, -811, -814, -817, -822.1 and -824 of the Code of Virginia are set forth in Appendix D.

STATEMENT OF THE CASE

(a) The Parties

This antitrust action was brought in 1978 by respondents Virginia Academy of Clinical Psychologists ("VACP") and Robert J. Resnick, then president of VACP, against the Richmond Plan and the Roanoke Plan. VACP also named as defendants Medical Service of the District of Columbia, Inc. and the Neuropsychiatric Society of Vir-

ginia, Inc., but it voluntarily dismissed the former before trial, and both the district court and the Fourth Circuit agreed that the latter had not violated the antitrust laws.[3]

Both the Richmond Plan and the Roanoke Plan are nonprofit, nonstock Virginia corporations organized under a Virginia statute[4] authorizing "[a] group of physicians" to conduct "a plan or plans for furnishing prepaid medical . . . services." The Plans, like most Blue Shield plans, contract with their subscribers to provide prepaid medical treatment. Commercial health insurance companies, in contrast, generally pay only a fixed fee for any given treatment, which may or may not cover the cost of that treatment.

The Plans can provide prepaid medical treatment only because they enter into agreements with "participating" physicians under which the physicians accept the fees paid by the Plans as full payment for treating the Plans' subscribers. In fact, because Virginia law provides that participating physicians are "jointly and severally liable" on the insurance contracts made by the Plans, the participating physicians would have to treat the Plans' subscribers without charge if the Plans became insolvent.[5] A subscriber to one of the Plans may visit any physician he likes, including a non-participating physician, but must pay the difference if the non-participating physician charges more than the Plan has contracted to pay its participating physicians.

The Plans are subject to extensive and detailed regulation by the Bureau of Insurance of the Virginia State

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3. *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 469 F. Supp. 552, 558-59 (E.D. Va. 1979), *aff'd on this issue*, 624 F.2d 476, 483 (4th Cir. 1980).

4. Va. Code § 38.1-811 (included in Appendix D).

5. *Id.* § 38.1-814 (included in Appendix D).

Corporation Commission (the "SCC"). By statute the SCC assigns each Plan a specific territory, and each Plan is prohibited from selling health insurance to persons who do not live or work in its territory.[6] Thus by law the Plans cannot compete with each other, but each Plan is in direct competition with the hundreds of commercial health insurance companies doing business in Virginia.

(b) The Claims Policy

The focus of this case is a claims policy that has been followed by the Roanoke Plan since it was organized in 1945 and that was adopted by the Richmond Plan in 1972. This claims policy in effect amended the Plans' contracts with their subscribers by expanding the coverage of the contracts to include treatment by psychologists where: (1) the subscriber was referred to the psychologist by a physician; (2) the physician supervised the psychologist's treatment of the subscriber; and (3) the psychologist's bill was submitted to the Plan by the physician. Any physician, whether participating or non-participating, could perform these referral, supervision and billing responsibilities, and the claims policy prohibited the physician from adding any additional charges to the psychologist's bill.

The Plans' insurance contracts covered only "medically necessary services . . . performed or prescribed by a Physician." Since psychologists are not physicians, treatment by psychologists was outside the coverage of the Plans' contracts prior to the claims policy. Adoption of the claims policy expanded the insurance benefits covered under the Plans' contracts with their subscribers.

However, the Plans' insurance contracts cover only "medically necessary" treatment. There are many medical

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6. *Id.* § 38.1-822.1 (included in Appendix D).

procedures, such as purely cosmetic surgery, that are not medically necessary. Similarly, there are instances where psychotherapy, by a psychologist or a psychiatrist, would not be medically necessary. The physician referral and supervision requirements imposed by the claims policy made certain that the Plans did not pay for treatment by a psychologist of a nervous or mental disorder that had a physiological cause, such as a tumor, that only a physician could properly diagnose and treat. The physician-billing requirement, which did not permit any additional charge by the physician, was the only reliable and practical means of assuring compliance with the referral and supervision safeguards.

The Richmond Plan adopted this claims policy following an intensive, eighteen-month review by its management of the benefits being offered to its subscribers. At the time the Richmond Plan finally made this decision, virtually all commercial health insurance companies and federal and local government insurance programs had similar policies. In fact, the federal Medicare program will not pay for treatment by a psychologist unless the psychologist is an *employee* of a physician.[7]

(c) The Virginia Direct Payment Statute

On June 1, 1973 the Virginia "direct payment" statute[8] became effective. The Plans and the SCC interpreted this statute to require direct payments to psychologists for treatment rendered to the Plans' subscribers, thus abrogating the physician-billing requirement of the Plans' claims policy. From its enactment in 1973 until an amendment in 1979, the direct payment statute in effect applied

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7. Dep't of HEW, *Medicare Carriers Manual*, Part 3, ¶ 2050.1 (1975).

8. Va. Code § 38.1-824 (included in Appendix D).

only to Blue Shield plans and not to commercial health insurers.[9] The 1979 amendment extended the direct payment statute to include commercial health insurers.

The Plans considered the direct payment statute unconstitutional, and each Plan continued to follow its established claims policy in order, as the Fourth Circuit said, "to provoke a judicial resolution" of the statute's validity.[10] Indeed, the Richmond Plan notified the Virginia psychologists in writing of its intent not to comply with the statute[11] and actively encouraged the Virginia Psychological Association (the "VPA") to file a declaratory judgment action in state court to test the statute.[12] The VPA brought such a test case against the Richmond Plan, but voluntarily nonsuited the action after its motion for summary judgment was denied. (The facts surrounding this test case are set forth in a binding stipulation between the Richmond Plan and VACP that is attached as Appendix F.)

The SCC then brought an administrative proceeding to compel the Richmond Plan to amend its contracts to comply with the direct payment statute. The Roanoke Plan was not a party to the SCC action because it had changed its policy to comply with the direct payment statute

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9. *Id*, § 38.1-347.1, -360 and -824 (included in Appendix D). Sections 38.1-347.1 and 38.1-824 are both direct payment statutes; the former applies to commercial health insurers and the latter to the Plans. The 1979 amendment deleted a provision from § 38.1-360 that had exempted commercial health insurers from § 38.1-347.1 with respect to group health contracts, which were approximately 90% of all health insurance contracts carried by the commercial health insurers.

10. 624 F.2d at 482.

11. Letter dated May 25, 1973 from M. Roy Battista, then Vice President of the Richmond Plan, to Virginia psychologists, a copy of which is attached as Appendix E.

12. The Richmond Plan concluded on advice of counsel that it could not itself maintain a declaratory judgment action because of the lack of an actual case or controversy.

before the SCC proceeding began. On appeal from the SCC's decision against the Richmond Plan, the Virginia Supreme Court held that the statute was unconstitutional for the period before the remedial amendment in 1979.[13] Both Plans are now complying with the direct payment statute.

(d) Decisions Below

VACP alleged that the Plans adopted the claims policy in concert, and that the Plans conspired not to comply with the direct payment statute, all in violation of § 1 of the Sherman Act. After a four-day bench trial, the district court found for defendants on four independent grounds. The court held: first, that the claims policy is exempt from the Sherman Act under the McCarran-Ferguson Act; second, that each of the Plans adopted the claims policy separately and independently; third, that the decision not to comply with the direct payment statute, even if concerted, was legitimate First Amendment activity immune from the Sherman Act by the *Noerr-Pennington* doctrine; and finally that the claims policy is not an unreasonable restraint of trade in violation of the Sherman Act.[14]

The Fourth Circuit reversed.[15] First, in direct conflict with the tests set forth by this Court in *Group Health & Life Insurance Co. v. Royal Drug Co.*,[16] it held that the claims policy is not "the business of insurance" under the McCarran-Ferguson Act.[17] Next, the Fourth Circuit held

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13. *Blue Cross & Blue Shield v. Commonwealth*, No. 800056 (Va. S. Ct., August 28, 1980).

14. 469 F. Supp. at 557, 559, 560-62.

15. 624 F.2d at 480-84.

16. 440 U.S. 205 (1979.

17. The Fourth Circuit did not reach the question whether the claims policy is a boycott within the meaning of § 3(b) of the McCarran-Ferguson Act. The district court held that the claims policy is not a boycott under § 3(b). 469 F. Supp. at 562-63.

that the Plans were inherent conspiracies of physicians, and that their disobedience of the Virginia direct payment statute was not protected by the *Noerr-Pennington* doctrine because it was not a "true" exercise of First Amendment rights.[18] Finally, it held that the Plans' physician-billing requirement is an unreasonable restraint of trade in violation of the Sherman Act.[19]

After the Fourth Circuit's decision, the Virginia Supreme Court handed down its decision overturning the direct payment statute for the period before 1979, but upholding it following the remedial amendment. The Richmond Plan then began complying with the statute, and both Plans promptly moved the district court on remand to declare the entire case moot. On December 2, 1980, the district court denied the motion and ruled that the Plans may be required to accept and pay claims for services by psychologists rendered after January 1, 1972.

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18. The Fourth Circuit did not rely on the "sham" exception to the *Noerr-Pennington* doctrine. 624 F.2d at 482 n. 9.

19. The Fourth Circuit agreed with the district court that the Rule of Reason (rather than a *per se* rule) should be applied to the physician-billing requirement, and it did *not* hold that the district court's factual finding of reasonableness was "clearly erroneous" under Fed. R. Civ. P. 52(a). Instead, the Fourth Circuit disregarded both Rule 52(a) and settled principles of judicial administration by announcing that the district court's factual finding of reasonableness was only a "value judgment," 624 F.2d at 485, undertaking a *de novo* appellate trial of the facts, and reversing the district court's holding. *See* Rule 17.1(a) of the Rules of the Supreme Court (certiorari may be appropriate where a federal court of appeals has "so far departed from the accepted and usual course of judicial proceedings . . . as to call for an exercise of this Court's power of supervision").

REASONS FOR GRANTING THE WRIT

The decision of the Fourth Circuit below is in direct conflict with the decision of this Court in *Royal Drug.* Also, the Fourth Circuit's erroneous holding that the Plans are inherent conspiracies under § 1 of the Sherman Act can be read to threaten the very existence of many non-profit, nonstock Blue Shield plans, which insure eighty million people in the United States. Finally the decision denies important civil rights guaranteed to the Plans by the First Amendment and the *Noerr-Pennington* doctrine.

(a) The Fourth Circuit Refused to Follow This Court's Decision in Royal Drug

The McCarran-Ferguson Act exempts "the business of insurance" from the antitrust laws to the extent that it is (1) regulated by state law, and (2) not an "agreement to boycott, coerce or intimidate, or act of boycott, coercion, or intimidation" in violation of the Sherman Act.[20] The Fourth Circuit held that the claims policy at issue here is not "the business of insurance" because it supposedly does not involve an *underwriting* decision as to which risks are to be accepted:

> "[The] decision regarding psychologists was not whether to underwrite the risk of [nervous and mental] disorders or even the need for psychotherapy; rather it was a question of who [the Plans] would pay for such services. The coverage remained the same."[21]

The Fourth Circuit's determination that the claims policy does not involve underwriting is in the teeth of *Royal Drug,* where this Court defined Blue Shield's "underwriting

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20. 15 U.S.C. § 1013(b).

21. 624 F.2d at 484.

decision" as "insur[ing] against the risk that policyholders will be unable to pay for prescription drugs during the period of coverage."[22] Here the Plans, by the terms of their contracts, insured their subscribers against the risk of not being able to pay for "medically necessary" treatment "by a Physician." The claims policy in effect amended these contracts by extending coverage to include "medically necessary" treatment by psychologists. Plainly this expansion of coverage increased both the benefits to subscribers and the risks accepted by the Plans under the contracts. The independent decisions of the Plans to expand the coverage of their subscriber contracts is indistinguishable from the "underwriting decision" specifically recognized in *Royal Drug* and thus falls squarely within "the business of insurance." By the same token, the physician referral, supervision and billing requirements are inseparable parts of the underwriting decision to cover psychologists' services. Stated simply, these requirements define the scope of the expanded coverage and the additional risk accepted by the Plans.

Moreover, the claims policy constitutes "the business of insurance" because it directly affects the "reliability, interpretation and enforcement"[23] of the insurance contracts between the Plans and their subscribers. In fact, the claims policy effectively amended the contracts to include psychologists within the contracts' definition of "Physician." The physician-billing requirement was included as part of the claims policy specifically to make certain that treatment rendered by psychologists to subscribers (and paid for by the Plans) was "medically necessary" within the meaning of the Plans' contracts.[24] The

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22. 440 U.S. at 213.

23. *Id.* at 216. *See SEC v. National Sec., Inc.*, 393 U.S. 453, 460 (1969).

24. *See* 469 F. Supp. at 561.

physician-billing requirement is not a measure designed to fix or limit the prices charged by providers similar to the pharmacy agreements at issue in *Royal Drug.*[25] To the contrary, it is not only indispensable for the reliable enforcement of the Plans' expansion of coverage to include psychologists' services, but it was adopted as an interpretation of the Plans' contracts. Thus the claims policy, including the physician-billing requirement, is certainly "the business of insurance" under the "reliability, interpretation and enforcement" standard reaffirmed in *Royal Drug.*

The Fourth Circuit essentially merged into one the two distinct tests of "the business of insurance" set forth by this Court in *Royal Drug.* According to the Fourth Circuit's reasoning, the claims policy is not an "insurance decision," that is, a decision to underwrite a risk, and *therefore* is only "tangential" to the relationship between the Plans and their subscribers.[26] By making "underwriting" the sole gauge of whether the claims policy affects the Plans' contracts with their subscribers, the Fourth Circuit has read out of *Royal Drug* this Court's plain holding that a matter directly affecting the "reliability, interpretation and enforcement" of an insurance contract constitutes "the business of insurance" whether literally involving underwriting or not. This is a drastic, and wholly unjustified, narrowing of *Royal Drug.*

The Fourth Circuit has in effect appropriated to the federal courts jurisdiction to regulate insurance under the guise of the antitrust laws. Nothing could be more certain than that the claims policy is "the business of insurance" reserved exclusively for State regulation by the McCarran-Ferguson Act. Petitioners pray this Court to

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25. *See* 440 U.S. at 213.

26. 624 F.2d at 483-84.

grant certiorari and to reverse summarily the Fourth Circuit's holding that the claims policy is not "the business of insurance" within the meaning of the McCarran-Ferguson Act.

(b) The Fourth Circuit's Erroneous Holding That the Plans Are Inherent Conspiracies Can Be Read to Threaten the Existence of Many Blue Shield Plans

The Fourth Circuit held that there is "sufficient physician control" of the Richmond Plan "to bring its actions within the purview of Section 1 of the Sherman Act."[27] The basis of this holding is that a majority of the members of the board of directors of the Richmond Plan are physicians.

In reaching this conclusion the Fourth Circuit relied primarily on *United States v. Sealy, Inc.*[28] In *Sealy,* about thirty mattress manufacturers were licensed to make and sell Sealy mattresses in exclusive territories. The defendant Sealy, the licensor, was jointly owned by the thirty licensees, and Sealy's president and directors were all "nominees" of the licensees. Thus the small number of licensees directly and actively managed Sealy's affairs:

> "Control does not reside in the licensees only as a matter of form. It is exercised by them in the day-to-day business of the company including the grant, assignment, reassignment, and termination of exclusive territorial licenses. Action of this sort is taken either by the board of directors or the executive committee of Sealy, both of which, as we have said, are

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27. *Id.* at 481. The Roanoke Plan, according to the Fourth Circuit, is "similarly structured." *Id.*

28. 388 U.S. 350 (1967).

manned, wholly or almost entirely, by licensee-stockholders."[29]

Under these circumstances, this Court held that Sealy was a combination of its licensees within the meaning of § 1 of the Sherman Act.

Sealy is totally inapplicable to the Plans here. There are approximately 4,000 physicians participating in the Plans, and these physicians exercise "control" of the Plans "only as a matter of form."[30] Certainly the physicians have no influence over the "day-to-day business" of the Plans. To the contrary, each of the Plans is indistinquishable from an ordinary, widely-held corporation, and therefore the Plans should be treated under the black-letter rule that a corporation cannot conspire with itself.[31]

In addition, this Court in *Sealy* found that the exclusive territorial licenses at issue there were designed to promote the interests of the licensees.[32] The claims policy here, however, is directly contrary to the economic interests of the physicians who, according to the Fourth Circuit, conspired in adopting the policy. In the absence of the claims policy, the Plans' contracts would not have

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29. *Id.* at 353.

30. The Fourth Circuit's holding that the Plans are inherent conspiracies of physicians is flatly contradictory to its holding that the Plans did not conspire with the Neuropsychiatric Society of Virginia, Inc., the psychiatrists' professional association. 624 F.2d at 483. It makes no sense to hold, as the Fourth Circuit has, that the Plans can consult regarding the coverage of their subscriber contracts with an organization of physicians (many of whom also belong to the Plans) without conspiring under § 1 of the Sherman Act, while holding on the other hand that the Plans' internal policy-making procedures are conspiratorial.

31. *E.g., Nelson Radio & Supply Co. v. Motorola,* 200 F.2d 911, 914 (5th Cir. 1952), *cert. denied,* 345 U.S. 925 (1953); *Mackey v. Sears, Roebuck & Co.,* 237 F.2d 869, 873 (7th Cir. 1956), *cert. denied,* 355 U.S. 865 (1957).

32. 388 U.S. at 354.

covered the services of psychologists *at all*. If, as the Fourth Circuit found, psychologists compete with psychiatrists, then the claims policy improved the psychologists' competitive position to the disadvantage of psychiatrists and other physicians.

The implications of the Fourth Circuit's holding could be catastrophic. Blue Shield plans insure eighty million people in the United States. Since these plans all have physicians as members of their boards of directors,[33] the Fourth Circuit's inherent conspiracy holding could be construed to have extraordinarily far-reaching and deleterious consequences. This is especially true in light of the Fourth Circuit's erroneously narrow interpretation of the McCarran-Ferguson Act, *supra*. As a result of these holdings, routine decisions made by Blue Shield plans regarding coverage under their subscriber contracts could be subjected to challenge under the Sherman Act. For this reason alone, this Court should grant certiorari to review and reverse the decision of the Fourth Circuit.

(c) The Fourth Circuit's Decision Denies Important Civil Rights Guaranteed to the Plans and Their Participating Physicians by the First Amendment and the Noerr-Pennington Doctrine

It is well-established that activity protected by the First Amendment is exempt from the antitrust laws under the *Noerr-Pennington* doctrine.[34] Here the Plans elected not to comply with the Virginia direct payment statute

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33. It is significant that the Federal Trade Commission recently rejected a trade regulation rule that would prohibit individual physicians from serving as directors of Blue Shield plans. 45 Fed. Reg. 17019, 17020 n. 2 (March 17, 1980).

34. *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961), and *United Mine Workers v. Pennington*, 381 U.S. 657 (1965).

in order, as the Fourth Circuit said, "to provoke a judicial resolution" of the Plans' contention that the statute was unconstitutional.[35] The Plans' refusal to comply *did* provoke a judicial resolution, with the result that the direct payment statute through 1979 was invalidated by the Virginia Supreme Court.

Nonetheless, the Fourth Circuit held that the *Noerr-Pennington* doctrine did not apply here "because the Plans, especially Roanoke, never truly exercised [their First Amendment] right."[36] The Fourth Circuit did not explain why the Plans' good faith and open refusal to comply with an unconstitutional statute was not "true" First Amendment activity, nor did the Fourth Circuit cite any authority for this novel proposition. Here the Plans not only decided to disobey the statute, but the Richmond Plan also notified Virginia psychologists in writing that it would not comply and that it would maintain an "appropriate reserve" to pay psychologists' claims if the statute were upheld.[37] The Richmond Plan also encouraged the VPA to bring a test case.[38] Thus the Plans' activities were clearly meant "to provoke a judicial resolution" of the validity of the statute, and for this reason the Plans' activities are protected by the First Amendment.[39]

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35. 624 F.2d at 482. The Virginia Supreme Court's decision invalidating the direct payment statute for the period before 1979 was handed down two months after the Fourth Circuit's decision.

36. *Id.*

37. *See* the letter from the Richmond Plan to psychologists attached as Appendix E.

38. *See* the stipulation between the Richmond Plan and VACP attached as Appendix F.

39. *See Spence v. Washington*, 418 U.S. 405, 409-11 (1974) (conduct designed to communicate opposition to government action can be protected by First Amendment).

Federal courts in other circuits have recently held that the *Noerr-Pennington* doctrine protects gas stations that close in concert to protest government price regulations;[40] longshoremen who protest the invasion of Afghanistan by refusing to load ships bound for the Soviet Union;[41] and organizations that boycott states that refuse to ratify the Equal Rights amendment.[42] There is no principled distinction between these cases and the Plans' open and good faith refusal to comply with the statute here, and this Court should resolve this conflict by reversing the Fourth Circuit's holding.

In short, the Fourth Circuit's decision chills the exercise of important First Amendment rights, including the fundamental right to challenge an unconstitutional statute. This Court should grant certiorari to review and reverse the Fourth Circuit's unwise and dangerous narrowing of the *Noerr-Pennington* doctrine.

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40. *Crown Central Petroleum Corp. v. Waldman*, 486 F. Supp. 759, 766-68 (M.D. Pa.), *rev'd on other grounds*, [1980] 5 Trade Reg. Rep. (CCH) ¶63,635 (3rd Cir. November 17, 1980).

41. *Allied Internat'l, Inc. v. International Longshoremen's Ass'n*, 492 F. Supp. 334 (D. Mass. 1980).

42. *Missouri v. National Organization for Women, Inc.*, 620 F.2d 1301 (8th Cir. 1980), *cert. denied*, ... U.S. ....., 49 U.S.L.W. 3216 (October 6, 1980).

CONCLUSION

For all the foregoing reasons, the petition for writ of certiorari should be granted and the Fourth Circuit's decision reversed. In particular, petitioners submit that the Fourth Circuit's holding that the claims policy is not "the business of insurance" is in direct conflict with this Court's decision in *Royal Drug* and therefore should be summarily reversed and remanded.

Respectfully submitted,

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APPENDIX

APPENDIX A

VIRGINIA ACADEMY OF CLINICAL PSYCHOLOGISTS et al.

v.

BLUE SHIELD OF VIRGINIA et al.

Civ. A. No. 78-0496-A.

United States District Court,
E. D. Virginia,
Alexandria Division.

April 9, 1979.

Clinical psychologist and organization of clinical psychologists brought action against prepaid health care plans and neuropsychiatric society alleging violation of antitrust statutes and seeking injunctive relief. The District Court, Warriner, J., held that: (1) policy of health care plans of paying fee of clinical phychologist only if services were ordered by, supervised by, and billed through physician had effect on interstate commerce; (2) activities of health care plans in challenging state statute requiring direct reimbursements to psychologists could not accord basis for antitrust suit in that such activity was protected by First Amendment; (3) national accounts in which health care plans were participants were joint activity and contractual arrangements exempt from Sherman Anti-Trust Act by reason of state action exemption; (4) neuropsychiatric society's close cooperation with health care plan by urging plans to adopt policies governing payment to psychologist and by advising plan on implementation of policies did not amount to contract, combination or conspiracy within mean-

ing of Sherman Anti-Trust Act; (5) without conditions of supervision and referral by a physician, clinical psychologist would not render a competitive service with psychiatrists, and thus plans' policy was not illegally restraining psychologists in their trade; (6) provisions of contract between health care plans and subscribers concerning covered treatment for mental or nervous disease were partially exempt from antitrust scrutiny, and (7) policy of dealing with clinical psychologists only if their services were result of referral or supervision by physician and bill was forwarded to plan through physician were medically and economically necessary and reasonable, and thus such activity was not a boycott of psychologists.

Judgment for defendants.

1. Monopolies (Key) 12(1.9)

Conspiracy in restraint of trade which is solely intrastate with no effect on interstate commerce is not prohibited by Sherman Anti-Trust Act. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1; Code Va.1950, § 32-195.1 et seq.

2. Commerce (Key) 62.11

Where clinical psychologist and other members of association of clinical psychologists bought substantial amounts of out-of-state equipment and supplies and treated out-of-state patients, and amount of equipment and supplies bought by clinical psychologists decreased as business decreased, policy of prepaid health care plans governing payment of fees to clinical psychologists which adversely affected psychologists' business had effect on interstate commerce for purposes of action by psychologist against plans alleging violation of Sherman Anti-Trust Act. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1; Code Va.1950, § 32-195.1 et seq.

3. Constitutional Law (Key) 91

Monopolies (Key) 18

Collaboration between prepaid health care plans challenging statute requiring psychologists, among others, to be reimbursed directly for covered services by prepaid health care plans if psychologists are rendering services which they are licensed to perform did not form basis for Sherman Anti-Trust Act claim against health plans in that such activity was protected by First Amendment. Code Va.1950, § 32-195.10:1; U.S.C.A.Const. Amend. 1; Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

4. Monopolies (Key) 18

Where covered activities of two prepaid health care plans in servicing national accounts was conduct made necessary by state as sovereign, national accounts in which plans were participants were joint activity and contractual arrangements exempt from Sherman Anti-Trust Act by reason of state action exemption. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

5. Monopolies (Key) 12(1)

Sherman Anti-Trust Act does not prohibit business entity which needs information and advice from obtaining such information and advice from other knowledgeable business entities. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

6. Monopolies (Key) 18

Prepaid health care plan's decision to implement policy on payment to psychologists did not become conspiracy with neuropsychiatric society merely because plan and society both took essentially same position; plan was not liable for conspiracy for acting as its interests dictated

and its decision was an independent one. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

7. Monopolies (Key) 12(1.2)

It is against competitors that structures of antitrust laws most stringently apply.

8. Monopolies (Key) 18

Neuropsychiatric society's close cooperation with prepaid health care plan by urging plan to adopt policies concerning payments to clinical psychologists and by advising plan on implementation of policy did not amount to contract, combination or conspiracy as used in Sherman Anti-Trust Act. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

9. Monopolies (Key) 12(1.1)

It is only those contracts, combinations or conspiracies which are in restraint of trade or commerce which are prohibited by Sherman Anti-Trust Act. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

10. Monopolies (Key) 18

Clinical psychologist could render services competitive with psychiatrist only if performed under supervision and referral of medical doctors; thus, policy of prepaid health care plan of not paying for services of clinical psychologist unless under supervision and referral of medical doctor did not treat psychologist with any competitive disadvantage in that in absence of such conditions psychologists would not render a competitive service with psychiatrist and such policy did not illegally restrain psychologists in their trade. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

11. Monopolies (Key) 18

Billing procedures of prepaid health care plan requiring clinical psychologists to bill through physician were reasonable means of accomplishing end of assuring medical necessity for psychologist's services and meeting business necessity of plans.

12. Monopolies (Key) 18

McCarran-Ferguson Act partially exempts from antitrust laws the business of insurance to extent that such business is regulated by state law. McCarran-Ferguson Act, § 2(b), 15 U.S.C.A. § 1012(b).

13. Monopolies (Key) 18

Provisions of contracts between prepaid health care plans and subscribers governing covered treatment for mental and nervous disease were partially exempt from antitrust scrutiny by McCarran-Ferguson Act. McCarran-Ferguson Act, § 3(b), 15 U.S.C.A. § 1013(b).

14. Monopolies (Key) 18

Policy of prepaid health care plan to deal with clinical psychologist only if his services were result of referral and supervision by medical doctor and if bill was forwarded to plan through supervising doctor was medically and economically necessary and reasonable, and thus such activity did not constitute boycott within meaning of McCarran-Ferguson Act. McCarran-Ferguson Act, § 3(b), 15 U.S.C.A. § 1013(b).

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MEMORANDUM

WARRINER, District Judge.

This anti-trust action has been brought by the Virginia Academy of Clinical Psychologists (VACP), the professional organization of registered clinical psychologists in Virginia, and a practicing clinical psychologist, Dr. Robert J. Resnick, against Blue Shield of Virginia (BSV), Blue Shield of Southwestern Virginia (BSSWV), and the Neuropsychiatric Society of Virginia (NSV). The action is brought pursuant to Section 1 of the Sherman Act, 15 U.S.C. § 1, and the plaintiffs are seeking injunctive relief pursuant to 15 U.S.C. § 26.

The gravamen of plaintiffs' complaint is that the practice of defendants, allegedly a result of a conspiracy amongst the defendants, of paying the fee of clinical psychologists for out-patient psychological services rendered to subscribers of Blue Shield only when these services are ordered by, supervised by, and billed through a physician, amounts to a conspiracy in restraint of trade in violation of Section 1 of the Sherman Act.

As it is admitted that the policy complained of exists, the question for decision is whether it was the result of a

contract, combination, or consipracy and if so, whether such practice is a restraint of trade in violation of the Sherman Act. In view of the applicability of the McCarran-Ferguson Act to the medical insurnace contracts in question here, the additional issue of whether the practice complained of amounts to a boycott will be considered.

The Court, in its previous rulings on defendants' motion to dismiss and motion for summary judgment, has ruled that plaintiff VACP and plaintiff Resnick have standing to pursue this action. The Court has also ruled that plaintiffs are not guilty of laches and that it would not be appropriate to stay this action due to the pending State Corporation Commission proceedings. *See* memorandum opinion of Court filed 10 October 1978 and memorandum opinion and order of Court filed 13 November 1978.

[1] A conspiracy in restraint of trade that is solely intrastate with no effect on interstate commerce is not prohibited by Section 1 of the Sherman Act, 15 U.S.C. § 1. In a carefully reasoned opinion, the Third Circuit held that where a restraint on commerce decreases the amount of out-of-state equipment and supplies bought by the complainants, such a restraint is affecting interstate commerce and is thus prohibited by the Sherman Act. *Doctors, Inc. v. Blue Cross of Greater Philadelphia*, 490 F.2d 48, 50-54 (3rd Cir. 1973).

[2] In this case, there is testimony that plaintiff Resnick and other members of the VACP buy substantial amounts of out-of-state equipment and supplies and treat out-of-state patients. The amount of equipment and supplies bought by clinical psychologists decreases when their business decreases and since the complained of policy is shown to adversely affect plaintiffs' business, the Court holds that the policy has an effect on interstate commerce, as explained in *Doctors*.

Defendant BSV and defendant BSSWV exist pursuant to a Virginia statutory scheme for pre-paid health care plans. Va. Code § 32-195.1 *et seq.* (1973 Repl.). BSV is authorized by the State Corporation Commission to operate throughout most of the Commonwealth east of the Blue Ridge Mountains, except for a small area in Northern Virginia. BSSWV is authorized by the State Corporation Commission to operate in Southwest Virginia. The plans were organized in the 1940s by medical doctors as a way of guaranteeing payment for provided medical services rendered by them to their subscriber-patients.

Defendant NSV is a not-for-profit non-stock corporation whose members are psychiatrist-physicians who practice in Virginia. It is the professional organization of Virginia psychiatrists.

Plaintiff VACP is the professional organization of clinical psychologists in Virginia. Clinical psychologists, including plaintiff Resnick and members of the VACP, are licensed as practioners of "the healing arts" by the Virginia State Board of Medicine. Va.Code § 54-274 (1978 Repl.). In order to apply for a license as a clinical psychologist, a candidate must have a Ph. D. degree in clinical psychology and must have at least two years of approved supervised clinical experience, one of which must be post-doctoral. The candidates are then given written and oral examinations by the Virginia Board of Psychology, and if they pass those examinations, the Board recommends to the Virginia State Board of Medicine that they be licensed. It is the Virginia State Board of Medicine which actually issues the license and subsequently regulates and monitors their activities.

Since about 1962 major medical plans issued by the two Blue Shield defendants have included coverage for mental and nervous disorders and for psychotherapy as a

method of treating those disorders. Since about 1972, defendant BSV has reimbursed a patient for psychotherapy rendered outside a hospital only if he is treated by a psychiatrist or if he is treated by a clinical psychologist upon reference to and supervision by a physician with the psychologist's services billed through the physician. BSSWV has followed such policy since its inception in 1945 with certain exceptions noted hereafter.

Virginia law licenses both psychologists and psychiatrists to perform psychotherapy, Va.Code § 54-273 (1978 Repl.). Plaintiffs' complaint is that the policy of the Blue Shield defendants, allegedly arrived at by combination or conspiracy, of reimbursing patients who are treated by psychiatrists for psychotherapy but only reimbursing patients who are treated by clinical psychologists if the additional requirement of physician billing supervision, and referral are met, adversely affects plaintiffs' competitive position as a result of a conspiracy in restraint of trade.

Plaintiffs allege that in addition to the parties defendant, the Medical Society of Virginia, Blue Cross of Virginia, and Blue Cross of Southwestern Virginia are part of this cooperative undertaking in restraint of trade. These latter entities are not named as defendants. Unlike Blue Shield plans, Blue Cross plans deal solely with hospital costs and in-patient services. Plaintiffs acknowledged at trial that clinical psychologists are not capable of rendering in-patient psychotherapy in competition with psychiatrists in the absence of physician supervision. Thus only outpatient care is in contention in this case.

The Court will first address the issue of whether BSV and BSSWV have combined or conspired together in restraint of trade.

I

Defendant BSSWV now directly reimburses patients for psychologists' out-patient services if the definition of "physician" in the subscriber's contract includes "psychologists." Such a definition is contained in approximately 75 per cent of the current contracts issued by BSSWV. Nervous and mental disorders are covered only in major medical contracts and in more than 90 per cent of these contracts the definition of "physician" includes "psychologists."

[3] BSSWV has always opposed the payment of psychologists directly but has agreed to direct payment in most of its contracts, as noted above, because the Bureau of Insurance of the State Corporation Commission had disapproved the form of a major medical contract submitted which did not include "psychologists" in the definition of "physician."

This disapproval by the Bureau of Insurance followed the enactment of Va.Code § 32-195.10:1 (Supp.1978) by the General Assembly in 1973. This section is interpreted to require that psychologists, among others, must be reimbursed directly for covered services by prepaid health care plans where they are rendering services that they are licensed to perform.[1] Unbeknownst to the Board of Directors of BSSWV the contract language was changed by subordinate officials of BSSWV to meet the Bureau's objection. When the Board of Directors subsequently learned of the change inserted in their contracts, the Board decided to honor the provision but at the same time reiterated its opposition, as a matter of principle, to direct payment to unsupervised clinical psychologists.

Collaboration between BSSWV and BSV concerning the issue of payment to clinical psychologists has revolved

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1. It is the constitutionality of this statute that is at issue in the State Corporation Commission proceeding mentioned above.

in the main around the challenge in State tribunals to the Virginia statutory scheme requiring such direct payment. BSSWV and BSV sought to bring a declaratory judgment action in the State court. Then it was decided, in consultation with counsel for VACP, that a suit by a patient who was not reimbursed for the services of a clinical psychologist would be the best means of challenging the statute. This test case was filed but was subsequently non-suited at the instance of VACP. Finally, BSV brought the matter before the State Corporation Commission where it is pending or from which it is being appealed.

Though BSSWV is not now directly participating in the State legal actions, its collaboration with BSV cannot afford a basis for a Sherman Act suit since the activity is protected by the First Amendment. *California Motor Transport Co. v. Trucking Unlimited,* 404 U.S. 508, 510-11, 92 S.Ct. 609, 30 L.Ed.2d 642 (1972); *United Mine Workers v. Pennington,* 381 U.S. 657, 669-670, 85 S.Ct. 1585, 14 L.Ed.2d 626 (1965); *Eastern Rr. President's Conf. v. Noerr Motor Freight, Inc.,* 365 U.S. 127, 138, 81 S.Ct. 523, 5 L.Ed.2d 464 (1961).

[4] The only other joint activity between BSSWV and BSV centered around their participation in various national accounts, including the Commonwealth contract, the major medical insurance plan for employees of the Commonwealth. The Commonwealth contract involves defendant BSV, defendant BSSWV, and the Medical Service of the District of Columbia. BSV negotiated the contract with the Commonwealth, receives the premium paid by the Commonwealth, maintains subscriber records, and controls the administration of the contract. Defendant BSSWV did not participate in the negotiations, does not receive any direct payment from the Commonwealth,

and does not exercise any control over the administration of the contract. Other than a requirement by the Commonwealth that all three Blue Shield organizations sign the contract, this contract is similar to other national accounts.

In a national account the "control" Blue Shield organization negotiates the contract and determines the benefits available and rate to be paid for those benefits. Other plans, known as participating plans, act as agents for the control plan in administering the claims of subscribers who are members of the subscribing group residing in the service area of the participating plan. The participating plan makes payment only for those benefits covered by the contract between the control plan and the group. These national accounts exist to accommodate to the difference between a covered group's geographic dispersion and the specific territories assigned Blue Shield organizations by State regulatory agencies. Thus when there is a contract with a group whose beneficiaries reside in more than one Blue Shield area, national account coverage is provided.

National accounts require cooperation among participating Blue Shield organizations. The Commonwealth contract and the other national contracts require just such cooperation between the two Blue Shield defendants. It is State law which divides the service areas and which thus compels the two Blue Shield defendants to cooperate in order to provide service throughout the Commonwealth. Such State regulatory activity is at the heart of the State action exemption to the anti-trust laws enunciated in *Parker v. Brown*, 317 U.S. 341, 350-1, 63 S.Ct. 307, 87 L.Ed. 315 (1943).

In *Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 413, 98 S.Ct. 1123, 1137, 55 L.Ed.2d 364, 383

(1977) it is stated "that the *Parker* doctrine exempts only anticompetitive conduct engaged in as an act of government by the State as sovereign." The cooperative activities of the two Blue Shield defendants in servicing national accounts is conduct made necessary by the State as sovereign. It is only the sovereign which regulates by force of law, and it is State law that divides the Commonwealth into service areas thus forcing the Blue Shield defendants to cooperate on national accounts. The Court thus concludes that the national accounts, including the Commonwealth contract, in which both Blue Shield defendants are participants, are joint activity and contractual arrangements exempt from the Sherman Act by reason of the State action exemption.

In any event, this cooperation or combination is not that which plaintiff decries and it is not shown to be in restraint of trade.

II

[5] There is no evidence that defendant NSV acted in conjunction with defendant BSSWV in establishing the clinical psychologist payment policy. Plaintiff does not seriously so contend. The main thrust of plaintiffs' case is that such a combination or conspiracy existed between NSV and BSV. A review of the live testimony, the documentary evidence, and the deposition extracts convinces the Court that this corporate policy of BSV was promulgated by the management and the Board of Directors of BSV after consultation with various provider groups, including groups representing psychologists and psychiatrists. The final decision, however, to adopt the policy was made solely by BSV's policy making bodies.

BSV had been inconsistent in its policy during the 1960's and early 1970's in regard to payment of clinical

psychologists. There is evidence that clinical psychologists had been paid for services independently rendered and yet it is not clear that this was company policy. Instead it appears that it resulted from a lack of company policy. In any event, the explosion of claims for nervous and mental disorders which occurred in the late 1960's came to the attention of the then new president of BSV, Alden Flory, and in 1971 it was decided that policy controls were needed.

In determining what should be the proper coverage for nervous and mental disorders the staff of BSV was instructed to secure the views of the various provider groups. Among those consulted were the Medical Society of Virginia, the Virginia Psychological Association, NSV, representatives of the Virginia Institute of Pastoral Care, psychiatric social workers, psychiatric nurses, and others. Although plaintiff VACP was not a separate entity at the time, the views of clinical psychologists were expressed through the Virginia Psychological Association.

NSV closely cooperated with BSV and gave assistance to BSV as it formulated policies in regard to who should be paid for providing mental health care, how much they should be paid, when they should be paid, and for what they should be paid. On 3 March 1971, L. W. Hulley, Jr., M.D., the head of BSV's professional relations committee met with R. Terrell Wingfield, M.D., President of NSV. Over the next year there was a substantial amount of communication between the two organizations. On 19 May 1971 at Blue Shield's corporate headquarters, a special committee of NSV met with representatives of BSV and discussed a large number of items dealing with payment to psychiatrists and clinical psychologists. A second meeting was held on 9 June 1971 at Tucker Hospital in Richmond. An extensive survey of Virginia psychiatrists, including those who did not belong to NSV, regarding

psychiatric practice was provided BSV by NSV. The insurance committee of NSV met with representatives of defendant BSV. The day before the adoption of BSV's interim corporate policy on 22 February 1972, the policy which set the general guidelines as to payment, representatives of BSV had met with representatives of NSV.

These committee meetings were working meetings and the officials of NSV were of substantial assistance to the officials of BSV in formulating the policy at issue in this lawsuit. Defendant NSV notes that the report of its committee was never officially adopted by the membership of NSV but instead it was referred to the President of NSV for further work. It is also true that not all of defendant NSV's recommendations were adopted by defendant BSV. Additionally, NSV points out that it took no position on the bill passed by the General Assembly mandating direct payment to psychologists. But this in no way detracts from the fact that NSV and BSV cooperated closely in 1971 and 1972. There is also no question that the two entities concurred that clinical psychologists should be paid for psychotherapy only when rendered under the supervision of a physician. The question for the Court is whether this cooperation amounted to a "contract, combination in the form of trust or otherwise, or conspiracy" according to the language of Section 1 of the Sherman Act, 15 U.S.C. § 1.

As pointed out above, BSV also consulted with representatives of other provider groups. It was only after all such consultation that the management and Board of Directors of BSV decided that as only medical doctors could ultimately determine the medical necessity of treatment for nervous and mental disorders, clinical psychologists would only be reimbursed for services rendered where there was referral to, supervision by, and billing through a medical doctor.

Though prior inquiry, consultation, and negotiation clearly took place, no contract was entered into, no combination was formed, and no conspiracy existed. Section 1 of the Sherman Act does not prohibit a business entity which needs information and advice from obtaining information and advice from other knowledgeable business entities. The operation of a medical insurance plan would be, for all practical purpose, impossible if consultation and cooperation with provider groups were barred.

[6] The problem of what constitutes a "contract, combination in the form of trust or otherwise, or conspiracy" has continually confronted the Courts. In *United States v. Standard Oil Co.*, 316 F.2d 884, 896 (7th Cir. 1963), where 11 corporate defendants, all oil companies, were appealing their convictions of conspiracy to raise retail gasoline prices, the Court held that there can be no conspiracy where there is no conscious commitment to a common scheme. The Court noted that "certainly, any defendant which heard of Standard's price announcement was not thereby immobilized and precluded from acting in a normal fashion as its interests might dictate so long as it was not pursuant to an understanding or agreement." *Standard Oil*, 316 F.2d at 896. Similarly, BSV's decision to implement its policy on payment to psychologists does not become a conspiracy with NSV because both took essentially the same position. On the reasoning of *Standard Oil*, BSV is not liable for conspiracy for acting as its interests dictated because BSV's decision was an independent one.

[7] Additionally, in contrast to the instant case, the parties who acted in *Standard Oil* were competitors. And it is against competitors that the strictures of the antitrust laws most stringently apply. *See Ark Dental Supply Co. v. Cavitron Corp.*, 461 F.2d 1093, 1094 (3rd Cir. 1973);

Joseph E. Seagram Sons, Inc. v. Hawaiian Oke Liquors, Ltd., 416 F.2d 71, 78 (9th Cir. 1969), *cert. den.* 396 U.S. 1062, 90 S.Ct. 752, 24 L.Ed.2d 755 (1970).

In *Scranton Construction Co. Inc. v. Litton Industries Leasing Corp.*, 494 F.2d 778 (5th Cir. 1974), *cert. den.* 419 U.S. 1105, 95 S.Ct. 774, 42 L.Ed.2d 800 (1975) the Court confronted a situation where defendant Litton engaged in rather unsavory business dealings for the express purpose of assuring that defendant United Cement received a certain subcontract on a construction project. Plaintiff, an unsuccessful bidder against defendant United Cement, alleged a conspiracy under the anti-trust laws between defendant Litton and defendant United Cement but the Court held that the independent business decisions of defendant Litton, though helpful to defendant United Cement, were not the bases of a combination or conspiracy. *Scranton Construction*, 494 F.2d at 782-83. So here, the independent business decision of BSV, though arguably helpful to NSV, does not form the basis of a combination or conspiracy with NSV.

[8] In sum, NSV cooperated closely with BSV by urging BSV to adopt the policies in question and by advising BSV on their implementation. But this does not amount to a "contract, combination . . . or conspiracy" as used in Section 1 of the Sherman Act. *Scranton Construction Co.; Standard Oil Co.*

III

[9] Even if it be found that the above activity amounts to an illegal contract, combination or conspiracy, the question of whether it operated in restraint of trade needs to be addressed for it is only those contracts, combinations and conspiracies "in restraint of trade or com-

merce" that are prohibited by Section 1 of the Sherman Act.

NSV first contends that all its activity amounts to no more than taking a position on a matter of public interest and it is thus protected under the First Amendment. That question need not be dealt with at length because the private meetings between the representatives of defendants NSV and BSV which discussed the range of psychiatric benefits, who was to provide them, and who was to be paid for them, were not equivalent to taking a position on a matter of public interest. Though infected with a public interest, this was not the expression of a viewpoint concerning the provision of health care in a public forum. These were private consultations and working sessions where implementation of defendants' corporate policy was discussed. *California Motor Transport Co. v. Trucking Unlimited,* 404 U.S. 508, 515, 92 S.Ct. 609, 30 L.Ed.2d 642 (1972).

The question remains, assuming the conspiracy, whether the policy is in restraint of trade. In approaching this question, the Court is mindful of the rule, recently reiterated in *Continental T.V. Inc. v. GTE Sylvania, Inc.,* 433 U.S. 36, 49 n.15, 97 S.Ct. 2549, 53 L.Ed.2d 568 (1977) that anti-trust cases must be read in their factual context.

The starting point in deciding the proper factual context for this case is deciding what sector of the economy is affected. Once the Court has identified the proper sector it can analyze whether defendants' actions have endangered competition within that sector. In other words, the Court looks to see who is competing with whom so as to understand whether defendants' actions restrain trade to the detriment of plaintiffs. *Cf., John Lenore & Co. v. Olympia Brewing Co.,* 550 F.2d 495, 498-9 (9th Cir. 1977); *In re Multi-district Vehicle Air Pollution,* 481 F.2d

122, 126 (9th Cir. 1973); *G.A.F. Corp. v. Circle Floor Co., Inc.*, 463 F.2d 752, 757 (2nd Cir. 1972), *cert. dismissed*, 413 U.S. 901, 93 S.Ct. 3058, 37 L.Ed.2d 1045 (1973).

[10] The fundamental premise of plaintiffs' case is that clinical psychologists are equal providers of therapy, in particular psychotherapy, with psychiatrists. It is true that both psychologists and psychiatrists professionally render psychotherapy to patients. But in the treatment of nervous and mental disorders, psychiatrists are capable of providing a full range of psychiatric treatments, not just psychotherapy. In addition, as medical doctors psychiatrists may render medical treatment and diagnosis. It is undisputed that clinical psychologists are not qualified to diagnose nervous and mental disorders and to decide from what source these disorders stem. What appears to be a nervous or mental condition is often the result of a physical illness or disturbance which a psychiatrist is qualified and licensed to analyze but which a clinical psychologist is not. Plaintiffs themselves acknowledge that the best practice for clinical psychologists to follow before psychotherapy is referral to a physician for a physical examination. This is unanimously agreed to be necessary so as to rule out a physical cause of the nervous or mental problem. Psychotherapy is to a substantial extent useless if the disease has a physical etiology.

It is also undisputed that the only method of making sure that a physical disorder does not complicate treatment by a clinical psychologist is regular contact between the psychologist's patient and a medical doctor. Whether this be called supervision, or referral on a regular basis, the medical necessity for this practice, in most, if not all cases, is undisputed.

It thus appears that the clinical psychologist is not competitive with the psychiatrist in regard to the treat-

ment of nervous and mental disorders unless the clinical psychologist is working under the supervision of a medical doctor. The competition, then, is, on the one hand, between the clinical psychologist working with a medical doctor and, on the other hand, the psychiatrist working alone. In this light, defendant BSV and defendant BSSWV treat the two competing entities equally so long as they both are shown to be providing medically necessary treatment. There is an exception to this equality of treatment. Clinical psychologists must submit their statement of fee to Blue Shield via the supervising physician.

The Court can well understand that plaintiffs do not like to bill through a physician as a matter of professional pride. The evidence shows that billing through a medical doctor is a requirement of the Blue Shield plan as a means of ascertaining that the treatment given and billed for was medically necessary. This procedure also tends to promote contact between the clinical psychologists and the physicians at all stages of the treatment, and thus enhances the supervisory process.

Plaintiffs, admitting the efficacy of referral and supervision, have not come forward with another plan that would be as economically and medically efficient. Indeed, Dr. William Dunn, then president of VACP, wrote the president of defendant BSV following a meeting on 14 October 1976, that "the arguments that you and your staff have tendered in defense of your position we recognize not only to be sound, but from a business point of view, virtually inevitable." On the facts presented, the Court concurs in this view.

If one group of providers, equal in rendering service with a second group, were suing the other group of providers and the Blue Shield defendants because the Blue Shield defendants reimbursed subscribers who receive

services from the second group but not the first, and such policy arose from a combination, contract or conspiracy, then a restraint of trade might well be stated. *Proctor v. State Farm Mut. Auto. Ins. Co.*, 182 U.S.App.D.C. 264, 277-8, 561 F.2d 262, 275-6 (1977), *vacated and remanded on other grounds*, ... U.S. ....., 99 S.Ct. 1417, 59 L.Ed.2d 631 (1979). But that is not this case. The medical necessity of supervision and referral along with the economic necessity of billing through a physician render this situation substantially different. Here, it is only within these conditions that the plaintiffs can render services competitive with psychiatrists. And with these conditions met, the defendant BSV treats plaintiffs without any competitive disadvantage. Without these conditions met, the clinical psychologists are not rendering a competitive service and thus defendant's policy is not illegally restraining plaintiffs in their trade.

[11] As a final plea plaintiffs contend that even though the medical necessity of referral and supervision is not contested, the billing procedures cannot be defended on the basis of business necessity nor as a required check on medical necessity since other Blue Shield plans (including defendant BSSWV) and other health insurance companies do not require such procedures. Those cases are not before the Court. The billing procedures in the instant case are a reasonable means of accomplishing the end of assuring medical necessity and meeting business necessity. As there is no evidence before the Court that those goals are as adequately met by the procedures used by other Blue Shield plans the fact that other Blue Shield plans use different methods is of no moment.

The Court has held, then, that defendants have engaged in no contract, combination or conspiracy and that

the policies complained of are not in restraint of trade. Thus there is no violation of Section 1 of the Sherman Act.

IV

[12] Considering the fact that the trial of this case revolved almost wholly around plaintiffs' contention that defendants' conduct amounted to a boycott, and considering the fact that if the Court has erred in its holding that there is no Sherman Act violation the question arises whether the questioned activity, if not a boycott, is exempt from the prohibitions of the anti-trust laws by the McCarran-Ferguson Act, 15 U.S.C. 1012(b).

McCarran-Ferguson partially exempts from the anti-trust laws "the business of insurance" to the extent such business is regulated by state law. The core of the business of insurance has been held to be "the relationship between the insurance company and the policyholder." *S.E.C. v. National Securities, Inc.*, 393 U.S. 453, 460, 89 S.Ct. 564, 569, 21 L.Ed.2d 668 (1969).

[13] The question of what is the "business of insurance" for McCarran-Ferguson Act purposes has recently arisen in the context of Blue Shield plans in *Group Life & Health Insurance Co. v. Royal Drug Co., Inc.*, ... U.S. ....., 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979). There the question for decision was whether contracts between participating pharmacies and Blue Shield of Texas which set the price for drugs sold by the pharmacies to Blue Shield subscribers were within the business of insurance exemption of the McCarran-Ferguson Act. The Court held that contracts between Blue Shield and providers, there the participating pharmacies, were not the business of insurance and thus were not exempt from anti-trust scrutiny.

The contracts in question here are not between providers and Blue Shield but between subscribers and Blue Shield. These provisions define what medical services are covered in the contract and thus are at the core of the business of insurance.

Dicta in *Royal Drug,* ..... U.S. at ....., 99 S.Ct. at 1079, might be interpreted to indicate that Blue Shield organizations are wholly outside the business of insurance. The Court's discussion in *Royal Drug* is in the context of whether Congress considered Blue Shield plans to be engaged in the business of insurance when it passed the McCarran-Ferguson Act.

Directly on point, however, is the footnote in *Royal Drug,* ..... U.S. at ....., n.37, 99 S.Ct. at 1082, n.37: "This is not to say that the contracts offered by Blue Shield *to its policyholders,* as distinguished from its provider agreements with participating pharmacies, may not be the 'business of insurance' within the meaning of the Act." (Emphasis added.) This tentative exception coupled with the definition of the business of insurance in *National Securities,* leads this Court to hold that Blue Shield subscriber contract provisions concerning covered treatment for mental and nervous disease are partially exempt from anti-trust scrutiny by the McCarran-Ferguson Act.

V

[14] The McCarran-Ferguson Act only provides partial exemption as it reads in part: "Nothing contained in this chapter [15 U.S.C. § 1011 *et seq.*] shall render the said Sherman Act [15 U.S.C. § 1 *et seq.*] inapplicable to any agreement to boycott, coerce, or intimidate." 15 U.S.C. § 1013(b). Plaintiffs do not claim coercion or intimidation but, as noted, the main thrust of plaintiffs' case cen-

tered around the claim that defendants' activity amounted to a boycott.

Just recently the Supreme Court decided a conflict among the Circuit Courts of Appeal as to the definition of boycott in the McCarran-Ferguson Act. *St. Paul Fire & Marine Ins. Co. v. Barry,* 438 U.S. 531, 549, 98 S.Ct. 2923, 2934, 57 L.Ed.2d 932, 946 (1978) holds that the definition of boycott for McCarran-Ferguson Act purposes is the same as a boycott under the general anti-trust laws. It rejected the narrower reading that the boycott exception was meant only to apply to " 'blacklists' of insurance companies or agents by other insurance companies or agents." *Barry,* 438 U.S. at 536, 98 S.Ct. at 2927, 57 L. Ed.2d 938, n.5. In the same footnote, the Supreme Court noted with apparent approval that the Fourth Circuit and the D.C. Circuit had previously adopted the broader reading of the definition of boycott. The Court will now consider the defendants' conduct in this case in light of the two cited circuit court decisions which adopted the broad view.

In *Ballard v. Blue Shield of Southern W.Va., Inc.,* 543 F.2d 1075 (4th Cir. 1976), *cert. denied,* 430 U.S. 922, 97 S.Ct. 1341, 51 L.Ed.2d 601 (1977), it was alleged that the defendant Blue Shield corporations of West Virginia refused to deal on any terms with chiropractors. The Fourth Circuit ruled on appeal from the granting of a motion to dismiss that this concerted refusal to deal on any terms alleged a boycott under the McCarran-Ferguson Act. Such a refusal to deal does not exist in the instant case. There cannot be a refusal to deal when plaintiffs' complaint is that the terms on which they are dealt with are disadvantageous. Although *Ballard* might be seen as merely an exclusion from coverage, the Fourth Circuit, on an appeal from a dismissal, accepted the allegations to

state a classic boycott case. Plaintiffs' complaint in this case is in regard to conditional coverage given to defendants' subscribers.

The other case cited by the Supreme Court was *Proctor*. In *Proctor,* 182 U.S. App.D.C. 277-78, 561 F.2d at 275-76, Judge McGowan analyzed the term "boycott" in the McCarran-Ferguson context. Judge McGowan was dealing with a situation where it was alleged that defendant insurance companies would reimburse policyholders for automobile repairs if certain repair shops were used but not if other repair shops were used. *Proctor* held that placing conditions on the use of repair shops by the policyholder was not an unconditional or unreasonable refusal to deal and thus did not amount to a boycott.

The line drawn between Judge Butzner in *Ballard* and Judge McGowan in *Proctor* appears to be that an unconditional refusal to deal or a refusal to deal except on unreasonable terms can amount to a boycott but a conditional refusal to deal, where the conditions are reasonable, does not amount to a boycott under McCarran-Ferguson. The facts in the instant case clearly fall in the latter situation. Defendants deal with clinical psychologists but only when their services are a result of referral and supervision and when the bill is forwarded to Blue Shield via the supervising physician. The Court has previously analyzed these requirements and finds them medically and economically necessary and reasonable. This Court believes, then, that the decision herein does not offend *Ballard* and is sanctioned by *Proctor.*

Thus it appears that the McCarran-Ferguson exemption is applicable, that the activity is not a boycott, and that even if it would otherwise be illegal activity under

the Sherman Act, McCarran-Ferguson removes any legally enforceable right plaintiffs might have had.

For the foregoing reasons, judgment will be rendered for defendants.

An appropriate order shall issue.

APPENDIX B

VIRGINIA ACADEMY OF CLINICAL PSYCHOLOGISTS, and Robert J. Resnick, Ph.D., Appellants,

v.

BLUE SHIELD OF VIRGINIA, Blue Shield of Southwestern Virginia, and Neuropsychiatric Society of Virginia, Inc., Appellees,
American Psychological Association, Amicus Curiae.

No. 79-1345.

United States Court of Appeals, Fourth Circuit.

Argued Feb. 5, 1980.

Decided June 16, 1980.

Organization of clinical psychologists and practicing clinical psychologist brought Sherman Act action against two Blue Shield plans and a neuropsychiatric society based on plans' refusal to pay for services rendered by clinical psychologists unless such services were billed through physicians. The United States District Court for the Eastern District of Virginia, at Alexandria, D. Dortch Warriner, J., 469 F.Supp. 552, entered judgment for defendants and plaintiffs appealed. The Court of Appeals, K. K. Hall, Circuit Judge, held that: (1) joint action of the plans challenging state statutory scheme requiring direct payment to clinical psychologists was not protected by *Noerr-Pennington* doctrine, which protects First Amendment right to petition, although collaboration of the plans in defiance of statute may have been calculated to provoke judicial resolution of the plans' grievance, where it amounted to no more than agreement to persist in economically restrictive com-

mercial activity in face of state law designed to open up health care market; (2) evidence supported finding that there had been no conspiracy between the plans and the neuropsychiatric society; and (3) the joint policy by the plans were in restraint of trade as proscribed by Sherman Act, since the policy forced the two independent economic entities, the psychologists and the psychiatrists, to act as one, with necessary result of diminished competition in health care field.

Affirmed in part, vacated and remanded in part.

1. Monopolies (Key) 18

Physician control of Blue Shield plan was sufficient to bring its actions within purview of Sherman Act, where plan was organized under Virginia statute providing that group of physicians may control directly or through agency a plan for furnishing medical and surgical services, plan was made up of participating physicians who were reimbursed by it, state law required majority of board of directors of plan to be health care providers and bylaws of plan provided for a physician majority. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1; Code Va.1950, §§ 38.1-811, 38.1-817.

2. Constitutional Law (Key) 91

Monopolies (Key) 12(1)

Collective action of two Blue Shield plans in challenging state statute requiring direct payment to clinical psychologist, rather than paying for their services only if billed through physician, was not protected by *Noerr-Pennington* doctrine, which protects First Amendment right to petition, although collaboration of the plans in defiance of statute may have been calculated to provoke judicial resolution of the plans' grievance, where it amounted to no more than an

agreement to persist in economically restrictive commercial activity in face of state law designed to open up health care market. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1; U.S.C.A.Const. Amend. 1; Code Va.1950, §§ 38.1-810, 38.1-811, 38.1-817, 38.1-824.

3. Monopolies (Key) 12(1)

State action exemption from Sherman Act did not apply to collaboration of two Blue Shield plans in administration of national accounts, although state may have created need for cooperation by prohibiting plans from operating outside their assigned territories, since state did not compel defendants to exclude psychologists from direct coverage as plans had agreed to do. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1; Code Va.1950, § 38.1-824.

4. Monopolies (Key) 28(7.4)

In action by clinical psychologists organization and practicing clinical psychologist against Blue Shield plans and neuropsychiatric society on ground that plans' policy of refusing to pay for services rendered by clinical psychologist unless such services were billed through a physician violated Sherman Act, evidence supported finding that there had been no conspiracy between the plans and the neuropsychiatric society. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

5. Monopolies (Key) 12(1, 14)

Business does not violate Sherman Act by unilaterally choosing those with which it will conduct business. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

6. Monopolies (Key) 12(17)

Purchaser of services, acting independently, may lawfully solicit proposals from various providers and choose

from among them. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

7. Monopolies (Key) 18

It was not illegal for neuropsychiatric society, as "seller" of services, to recommend that Blue Shield plan refuse to cover services rendered by clinical psychologists unless billed through physicians, absent some form of coercion. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

8. Monopolies (Key) 18

Joint policy of two Blue Shield plans to refuse to pay for services rendered by clinical psychologists unless billed through physicians was not exempt from antitrust laws under McCarran-Ferguson Act on basis that state regulated business of insurance was involved, where both plans had been covering mental and nervous disorders for several years and their decision regarding psychologists was not whether to underwrite risk of disorders, or even the need for psychotherapy, but who would pay for such services. McCarran-Ferguson Act, § 2(b), 15 U.S.C.A. § 1012(b); Code Va.1950, § 38.1-824.

9. Monopolies (Key) 18

Joint policy by two Blue Shield plans to refuse to pay for services rendered by clinical psychologists unless billed through physicians was in restraint of trade as proscribed by Sherman Act, since policy forced two independent economic entities, psychologists and psychiatrists, to act as one, with necessary result of diminished competition in health care field. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1; Code Va.1950, §§ 38.1-811, 38.1-817.

Warwick R. Furr, II, Vienna, Va. (Thomas M. Brownell, Lewis, Mitchell & Moore, Timothy J. Bloomfield, Alan J. Kriegel, Dunnells, Duvall, Bennett & Porter, Washington, D.C., on brief), for appellants.

Joel I. Klein, Washington, D.C. (Eugene Comey, H. Bartow Farr, III, Rogovin, Stern & Huge, Washington, D.C., R. Gordon Smith, Gilbert E. Schill, Jr., James H. Walsh, McGuire, Woods & Battle, Richmond, Va., Ronald M. Ayers, Heman A. Marshall, III, Woods, Rogers, Muse, Walker & Thornton, Roanoke, Va., Francis J. Prior, Jr., Siciliano, Ellis, Sheridan & Dyer, Arlington, Va., on brief), for appellees.

Before HALL and PHILLIPS, Circuit Judges, and HOWARD*, District Judge.

K. K. HALL, Circuit Judge:

This controversy arises over the refusal by defendants Blue Shield of Virginia and Blue Shield of Southwestern Virginia to pay for services rendered by clinical psychologists unless such services are billed through a physician. Plaintiffs Virginia Academy of Clinical Psychologists and Dr. Robert J. Resnick, a practicing clinical psychologist, claim that this policy violates Section 1 of the Sherman Act. 15 U.S.C. § 1. The district court found no violation. *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia,* 469 F.Supp. 552 (E.D.Va.1979). We affirm in part and reverse in part.

Since 1962, Blue Shield of Virginia [BSV or the Richmond Plan] and Blue Shield of Southwestern Virginia [BSSV or the Roanoke Plan] have included outpatient cov-

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*Honorable Joseph C. Howard, United States District Court for the District of Maryland, sitting by designation.

erage for mental and nervous disorders and for psychotherapy as a method of treating those disorders. Between 1962 and 1972, Richmond Plan coverage included direct payment to psychologists for psychotherapy rendered to subscribers. In 1972, this policy was revised to allow payment only when the services were billed through a physician.

The revised policy of the Richmond Plan was announced after consultation with various provider groups, including the American Psychological Association and the defendant Neuropsychiatric Society of Virginia [NSV]. Contact between the Richmond Plan and NSV, however, was particularly close.

Beginning in 1971, Dr. Levi Hulley, M.D., the head of the Plan's professional relations committee, met several times with NSV's president, Dr. Terrell Wingfield, M.D., over the question of payment for psychotherapy. Cooperation between the two groups followed: NSV, at the Plan's request, conducted a survey of Virginia psychiatrists on various aspects of psychiatric practice and later passed a resolution recommending, inter alia, that the Richmond Plan terminate direct payment to clinical psychologists. Immediately prior to adopting its policy, Richmond Plan officials met with a special NSV committee to discuss the scope of mental health coverage. The Plan adopted some of NSV's recommendations, including that of refusing to cover services rendered by psychologists unless billed by a physician.

Following implementation of the non-payment policy, the Virginia legislature, in 1973, added another dimension to the problem by passing a "Freedom of Choice Statute" Va.Code § 32-195.10:1 [now amended and codified at § 38.1-

824], which requires Blue Shield plans to pay directly for services rendered by licensed psychologists.[1]

The passage of this legislation provoked discussion between the Roanoke Plan and the Richmond Plan, resulting in collaboration between the two Plans to continue denying direct payment to psychologists in violation of the statute and to pursue litigation to test the statute. A test case was filed in state court by a subscriber and her psychologist against the Richmond Plan, but was later voluntarily nonsuited. In 1976, the State Corporation Commission brought an action against the Richmond Plan to compel compliance with the statute. *Commonwealth of Virginia ex rel. State Corporation Comm'n v. Blue Cross of Virginia,* Case No. 19829.

The Roanoke Plan was not a party to either State proceeding, but maintained an official policy of denying payment, despite the statute, until November 1976. By the time this case was tried, however, most Roanoke Plan contracts allowed direct payment to psychologists.

This action was filed on July 14, 1978. Following the voluntary dismissal of defendant Medical Service of District of Columbia, Inc., a Blue Shield Plan operating in Northern Virginia, the case was tried to the court in

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1. The Statute provided:

§ 38.1-824. *Services of certain practioners other than physicians to be covered.*—No plan for furnishing prepaid medical and surgical, and similar or related services, or any of such services, shall fail or refuse, either directly or indirectly, to allow or to pay for such services, or any part thereof, rendered by any doctor of podiatry, doctor of chiropody, or optometrist, optician and psychologist duly licensed to practice in Virginia, to the holder of any contract or subscription contract issued under or pursuant to such plan if the services rendered (i) are services provided for by such contract or subscription contract . . . and, (ii) are services which the doctor of podiatry, doctor of chiropody or optometrist, optician and psychologist is licensed to render in Virginia. (1966, c. 276; 1973, c. 428.)

January 1979. On April 9, 1979, the district court issued a Memorandum Opinion and Order, holding: (1) Plaintiffs had failed to prove any contract, combination or conspiracy cognizable under Section 1 of the Sherman Act; (2) even if there was such an arrangement, it was not in restraint of trade; and (3) the defendants' conduct was exempt from the antitrust laws under the McCarran-Ferguson Act. 15 U.S.C. § 1012(b).

I

The district court held that the plaintiffs had failed to prove a "contract, combination . . ., or conspiracy" within the reach of Section 1 of the Sherman Act. First, it found that agreement between the two Blue Shield Plans was exempt from the Sherman Act. It held that the Plans' decision to challenge the Virginia "Freedom of Choice" legislation was protected activity under the First Amendment, and the joint administration of "national accounts" restricting payment to psychologists was within the "state action" exemption of *Parker v. Brown,* 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943). 469 F.Supp. at 557.

Second, the court found no agreement between the Plans and NSV. The court noted that "NSV cooperated closely with BSV by urging BSV to adopt the policies in question and by advising BSV on their implementation," but found that this was part of a program of consultation with many provider groups, including the American Psychological Association. The district court concluded:

> Though prior inquiry, consultation, and negotiation clearly took place, no contract was entered into, no combination formed, and no conspiracy existed. Section 1 of the Sherman Act does not prohibit a business entity which needs information and advice from obtaining information and advice from other knowl-

> edgeable business entities. The operation of a medical insurance plan would be, for all practical purposes, impossible if consultation and cooperation with provider groups were barred.

469 F.Supp. at 559.

a. Blue Shield

The district court treated the Plans as separate, independent entities. This characterization is only partly accurate. Noticeably absent from the district court's discussion is any mention of the plaintiff's principal theory on appeal: that the Blue Shield Plans are combinations of physicians, operating under the direction and control of their physician members.[2]

Blue Shield Plans are not insurance companies, though they are, to a degree, insurers. Rather, they are generally characterized as prepaid health care plans, quantity

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2. Provider control of the "Blues" has been the subject of considerable controversy in recent years, in Congress, *see Skyrocketing Health Care Costs. The Role of Blue Shield, Hearings before the Subcommittee on Oversight and Investigations, Committee on Interstate and Foreign Commerce, House of Representatives,* 95th Cong., 2d Sess. (1978), and the Federal Trade Commission, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans,* FTC Bureau of Competition (Apr. 1979) as well as in recent scholarly efforts. *See* M. Thompson, *Antitrust and the Health Care Provider,* 35 (1979); Goldberg and Greenberg, *The Effect of Physician Controlled Health Insurance: U. S. v. Oregon State Medical Society,* 2 J. Health Pol. Pol'y & L. 48 (1977); Havighurst, *Professional Restraints on Innovation in Health Care Financing,* 1978 Duke L.J. 303, 336-37, 348, 375-76 (1978); Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act,* 1978 Duke L.J. 645 (1978). The problem of provider control was also alluded to by the Supreme Court in *Group Life & Health Insurance Co. v. Royal Drug Co.,* 440 U.S. 205, 232 n.40, 99 S.Ct. 1067, 1083 n.40, 59 L.Ed.2d 261, 281 n.40.

In *United States v. Oregon Medical Society,* 343 U.S. 326, 72 S.Ct. 690, 96 L.Ed. 978 (1952), the provider control of Oregon Physicians Service was unchallenged, *id.* at 330, 72 S.Ct. at 694. Goldberg & Greenberg, *supra* at 65-66.

purchasers of health care services. *See Group Life and Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 225-232, 99 S.Ct. 1067, 1080-1083, 59 L.Ed.2d 261, 277-80 (1979). A plan may be viewed as an agent of its subscribers, a buyers cooperative. *See Jordan v. Group Health Association,* 71 App.D.C. 38, 107 F.2d 239 (1939). *But see Blue Cross v. Commonwealth,* 211 Va. 180, 176 S.E.2d 439, 443 (1970). But in a real and legal sense, the Blue Shield Plans are agents of their member physicians.[3]

The Virginia Statute authorizing the creation of Blue Shield Plans states:

> *Medical and Surgical Plans.*—A group of physicians may conduct directly or through an agent, who may be either an individual or nonstock corporation, a plan or plans for furnishing prepaid medical or surgical or similar or related services or both.

Va.Code § 38.1-811 [formerly codified at § 32-195.2]. The Plans in this case, organized under the above provision, are made up of "participating physicians" who as "members" of the plan contract to provide services to subscribers, and are reimbursed by the Plan.

State law requires that the majority of the board of directors of such a plan be "health care providers," Va. Code § 38.1-817. The by-laws of the Richmond Plan, however, until very recently, provided for a physician majority:

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3. A Blue Shield advertising brochure used until recently to attract physician membership stated:

> Blue Shield is a nationally recognized symbol of voluntary prepayment coverage for medical expenses. It is known as the "doctors' plan for the people," but it is, realistically also the doctors' plan for the doctors, with control and guidance originating from members of the medical profession.

> The board shall have fifteen members. Not less than eight of such members shall be Doctors of Medicine or Osteopathy who are engaged in active practice and who are members of the plan.

The Medical Society of Virginia is identified as "sponsor" of the Richmond program, and its by-laws indicate that five of the physician members of its board "shall be elected from among those designated by the Medical Society of Virginia."

The Supreme Court of Virginia emphasized collective nature of a similar type of plan in *Blue Cross v. Commonwealth,* 211 Va. 180, 176 S.E.2d 439 (1970). There the court held that certain Pharmacy Agreements entered into between Blue Cross and participating Pharmacists violated the Sherman Act. Among the several combinations found in that case was that of the participating hospitals which constitute Blue Cross, in the same fashion as participating physicians constitute Blue Shield. *Compare* Va.Code § 38.1-810 with § 38.1-811. The court characterized the arrangement as follows:

> The Blue Cross participating hospitals determined to inaugurate a plan for the furnishing of drugs to the subscriber-public. To implement the plan, they *chose to act in concert through Blue Cross as their agent* in setting the price at which they would deal with the sellers of drugs (the cooperating pharmacists). The Commission found that sellers of drugs knew they would lose business if they agreed to sell at the price set by Blue Cross.

Id. at 190, 176 S.E.2d at 445. (emphasis added).[4]

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4. The Blue Shield brochure described in note 3 continued:

> When new programs are established, they are sustained by reimbursement principles representing the collective judgments of area physicians acting through societies and through Board representation.

It is not sufficient to assert, as defendants do, that a corporation cannot conspire with itself. We must look at substance rather than form. *E. g. United States v. Sealy, Inc.*, 388 U.S. 350, 87 S.Ct. 1847, 18 L.Ed.2d 1238 (1967).[5] Antitrust law has always been sensitive to the realities of the marketplace and has been particularly watchful of organizations of the various trades or professions. *See, e. g. National Society of Professional Engineers v. United States*, 435 U.S. 679, 98 S.Ct. 1355, 55 L.Ed.2d 637 (1978); *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 95 S.Ct. 2004, 44 L.Ed.2d 572 (1975); *Silver v. New York Stock Exchange*, 373 U.S. 341, 83 S.Ct. 1246, 10 L.Ed.2d 389 (1963); *Radiant Burners, Inc. v. Peoples Gas Light & Coke Co.*, 364 U.S. 656, 81 S.Ct. 365, 5 L.Ed.2d 358 (1961); *Fashion Originators Guild v. Federal Trade Commission*, 312 U.S. 457, 61 S.Ct. 703, 85 L.Ed. 949 (1941).

[1] We think the uncontradicted evidence and district court findings show sufficent physician control of Blue Shield of Richmond to bring its actions within the purview of Section I of the Sherman Act.[6] *See United States v. Sealy, Inc., supra.*

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5. In *United States v. Sealy, Inc.*, the Supreme Court rejected the contention of Sealy manufacturer-licensees that their exclusive territories were vertically imposed by the licensor, Sealy, Inc. The Court found that Sealy, Inc. was substantially owned and controlled by the manufacturer-licensees, and therefore its action in allocating territories was actually a horizontal agreement between its licensee stockholders. *Accord, United States v. Topco Associates, Inc.*, 405 U.S. 596, 92 S.Ct. 1126, 31 L.Ed.2d 515 (1972).

6. A most illuminating illustration of the provider interest at work in the administration of the Plans is this statement by Levi W. Hulley, Jr., M.D., medical director of the Richmond Plan, which appears in the May 25, 1972 minutes of the Committee on Mental Health of the Medical Society of Virginia:

> *BLUE CROSS-BLUE SHIELD COVERAGE;* Dr. Hulley assured the Committee of the interest of Blue Cross-Blue Shield where psychiatric services are concerned and discussed a re-

(Continued on following page)

Although appellants' case focuses primarily on the activities of the Richmond Plan, the Roanoke Plan is similarly structured. Moreover, the district court found that the two Plans had "collaborated."[7] The court concluded, however, that the collaboration was exempt from Sherman Act scrutiny because it "revolved in the main around a challenge in State tribunals to the Virginia statutory scheme requiring such direct payment." 369 F.Supp. at 557. We do not think that the *"Noerr-Pennington* doctrine," upon which the court relied, is applicable to this case.

In *Eastern Railroad Presidents Conference v. Noerr Motor Freight,* 365 U.S. 127, 81 S.Ct. 523, 5 L.Ed.2d 464 (1961), a group of railroads had conducted a misleading advertising campaign designed to influence legislative action which would place trucking firms at a competitive disadvantage. The Supreme Court held that this conduct was protected by the First Amendment and therefore outside the Sherman Act despite its plainly anticompetitive purpose and incidental anticompetitive effects. In *United Mine Workers of America v. Pennington,* 381 U.S. 657, 85

Footnote continued—

port prepared under the direction of Dr. Wingfield and a special committee of the Neuropsychiatric Society.

The report is concerned with services provided by psychiatrists and charges involved. It has been referred to the Blue Shield Board for consideration and final disposition.

It was brought out that a number of groups, which have a part in the overall mental health picture, are little by little working their way into the therapy field. It seemed to be the consensus that The Medical Society of Virginia should take a firm stand on this encroachment and seek to stop it once and for all.

It was brought out that psychotherapy apparently means different things to different people and it was agreed that it should be defined as that performed by psychiatrists or under the direct supervision of psychiatrists.

7. *See American Motor Inns, Inc. v. Holiday Inns, Inc.,* 521 F.2d 1230, 1243 (3rd Cir. 1975).

S.Ct. 1585, 14 L.Ed.2d 626 (1965), the Court exempted from the Sherman Act an alleged collective effort by the union and mine operators to induce the Secretary of Labor to set a minimum wage so high that only larger government contractors could afford to sell coal to the TVA. The *Noerr-Pennington* exemption was later extended, in a somewhat narrower fashion, to genuine administrative and judicial litigation in *California Motor Transport v. Trucking Unlimited*, 404 U.S. 508, 92 S.Ct. 609, 30 L.Ed.2d 642 (1972).

The *Noerr-Pennington* doctrine protects the first amendment right to petition. *Feminist Women's Health Center v. Mohammad*, 586 F.2d 530, 542 (5th Cir. 1978); *see also California Motor Transport, supra*, 404 U.S. at 510, 92 S.Ct. at 611. The exemption does not apply in this case because the Plans, especially Roanoke, never truly exercised that right.

In response to the passage of Freedom of Choice legislation in Virginia, Officers of the two Plans met and decided to challenge the statute. Following the 1975 "Summit Meeting" at which the possibility of a declaratory judgment action was discussed, the Roanoke Plan brought itself into conformity with Richmond's policy of noncompliance by adopting a resolution to deny payment to psychologists in spite of the statute. The declaratory action was not pursued, and the court challenge against BSV by a psychologist and his patient was nonsuited and never revived. The challenge to the statute finally occurred, but at the instance of the State Corporation Commission[8] and did not include the Roanoke Plan.

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8. Contrary to the suggestion by the district court, it was the Commission and not BSV which brought the action. The constitutionality of the statute was upheld by the Commission. *Commonwealth of Virginia ex rel. State Corporation Comm. v. Blue Cross of Virginia*, Case No. 19829 (Feb. 14, 1979).

[2, 3] The collective action of the Plans in this case thus falls short of the activity protected by *Noerr-Pennington.*[9] The collaboration in defiance of the statute may have been calculated to provoke a judicial resolution of the Plans' grievance, but it amounted to no more than an agreement to persist in economically restrictive commercial activity in the face of a State law designed to open up the health care market. We think the efforts of States to promote competition and consumer choice through legislation would be seriously hampered if *Noerr-Pennington* were extended so that those who would flout such a law could avoid antitrust liability in the process.[10]

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9. We do not hold that the defendant's conduct was within the "sham" exception to the *Noerr-Pennington* doctrine. See *Noerr, supra,* 365 U.S. at 144, 81 S.Ct. at 533, *California Motor Transport, supra.* The "sham" exception applies when the right is actually exercised, but in a manner calculated to interfere directly with a competitor's business. Repeated frivolous litigation calculated to delay a competitor's licensing would be an illegal sham. But until the right to petition is exercised, the "sham" inquiry is not reached.

10. We are also unable to agree with the district court's application of the State action exemption to the collaboration of the Richmond and Roanoke Plans in the administration of "national accounts," the operation of which is fully described in the district court's opinion. 469 F.Supp. at 557-58. Although Virginia may have created a need for cooperation by prohibiting the Plans from operating outside their assigned territories, the State certainly does not compel the defendants to exclude psychologists from direct coverage. The application of the State action exemption in this case is thus precluded by our decision in *Ballard v. Blue Shield of Southern West Virginia, Inc.,* 543 F.2d 1075 (1976).

> [No] action on the part of West Virginia compels the defendants to exclude chiropractors from their insurance plans. West Virginia law specifically authorizes the defendant companies to insure the costs of chiropractic treatment, but the defendants have not elected to provide this coverage. Therefore they can claim no immunity under *Parker v. Brown. Cantor v. Detroit Edison Co.,* 428 U.S. 579, 96 S.Ct. 3110, 49 L.Ed.2d 1141 (1976); *Goldfarb v. Virginia State Bar,* 421 U.S. 773, 778-92, 95 S.Ct. 2004 [2008-15], 44 L.Ed.2d 572 (1975).

543 F.2d at 1079. *See also, California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.,* ..... U.S. ....., 100 S.Ct. 937, 63 L.Ed.

(Continued on following page)

b. Neuropsychiatric Society of Virginia

[4] Our decision as to the Blue Shield Plan does not affect the Neuropsychiatric Society of Virginia. The physician domination of Blue Shield does not necessarily render it unable to operate independently vis-a-vis other economic entities. The evidence shows that NSV cooperated very closely with the Richmond Plan and received more attention than other provider groups, but the evidence also shows that the Plan rejected some of NSV's proposals, while accepting others. We think there was a sufficient factual basis for the district court's finding that there was no conspiracy between the two groups.

[5-7] Plaintiffs failed to show that NSV had some control over Blue Shield's decision-making, or that Blue Shield agreed to abide by the decision of NSV in formulating its policy. It has long been recognized that a business may unilaterally choose those with which it will conduct business. *United States v. Colgate Co.*, 250 U.S. 300, 39 S.Ct. 465, 63 L.Ed. 992 (1919). A purchaser of services, acting independently, may lawfully solicit proposals from various providers and choose from among them. *E.g. Scranton Construction Co. v. Litton Industrial Leasing*, 494 F.2d 778 (5th Cir. 1974). Thus, it was not illegal for

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Footnote continued—

2d 233 (1980). In this case the state does not even permit the challenged policy; *A fortiori* it is not state action.

Despite our disagreement with the Court's reasoning, we do not rest our finding of liability on the cooperation of the plans in the management of these accounts. Each national account involves a contract between one "control plan" and subscriber whose employees reside in several Blue Shield territories. The terms are arrived at between those parties; and the "participating plans" act as the agents of the control plan in administering the contract in their respective areas. They are required to follow exactly the terms of the control contract, and are reimbursed by the control plan for their expenditures. This cooperation certainly is not in restraint of trade.

NSV, as "seller" of such services, to make recommendations aimed at persuading Blue Shield to adopt its proposal and use its services, absent some form of coercion. Accordingly, we affirm the judgment in favor of NSV.

II

[8] We next consider whether defendants' policy is exempt from the antitrust laws under the McCarran-Ferguson Act, 15 U.S.C. § 1012(b). To fall within that exemption the challenged conduct must be the State regulated "business of insurance," and not a boycott, 15 U.S.C. § 1913(b). *Group Life and Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979); *St. Paul Fire and Marine Ins. Co. v. Barry*, 438 U.S. 531, 98 S.Ct. 2923, 57 L.Ed.2d 932 (1978). We hold that the defendants' conduct is not the "business of insurance." Plaintiffs' assertion that they have been subjected to a boycott will be discussed in part III, *infra*.

In *Royal Drug, supra*, the Supreme Court held that certain Pharmacy Agreements, entered into between Blue Shield and participating pharmacies for the purpose of providing drugs at a cost to Blue Shield's policyholders of $2.00 per prescription, were not the "business of insurance." While the present case is distinguishable from *Royal Drug*, we think the Supreme Court's opinion sheds considerable light on this case.

The majority in *Royal Drug* explained that at the time of the enactment of the McCarran-Ferguson Act, activities of programs like Blue Shield were not considered to be insurance at all. 440 U.S. at 225-229, 99 S.Ct. at 1080-1082, 59 L.Ed.2d at 277-79. That discussion is not dispositive of this case, for the Supreme Court also noted,

> [t]his is not to say that the contracts offered by Blue Shield to its policyholders, as distinguished from pro-

> vider agreements with participating pharmacies, may not be the "business of insurance" within the meaning of the Act.

Id., 440 U.S. at 320 n. 37, 99 S.Ct. at 1082 n. 37, 59 L.Ed.2d at 279 n. 37. Nevertheless, the court's analysis reinforces our view that the exemption should be narrowly applied to Blue Shield plans, especially where provider control is in issue. *See, id.*, 440 U.S. at 232 n. 40, 99 S.Ct. 1083 n. 40, 59 L.Ed.2d at 280 n. 40.

The essence of the business of insurance is the relationship between the insurance company and its policyholder. *SEC v. National Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564, 21 L.Ed.2d 668 (1969); *Bartholomew v. Virginia Chiropractors Ass'n*, 612 F.2d 812 (4th Cir. 1979), *cert. denied* ..... U.S. ....., 100 S.Ct. 2158, 64 L.Ed.2d 791 (1980). We are persuaded that the defendants' policy regarding payment of clinical psychologists is only tangential to that relationship in that it does not affect the benefit conferred upon the subscriber.

Were we confronted with a decision by the Plans to deny payment for mental and nervous disorders for psychotherapy as a method of treating those disorders we might conclude that the decision was an insurance decision—the refusal to underwrite a specific risk. In the present case, however, both Plans have been covering these mental and nervous disorders in their contracts since at least 1962. Their decision regarding psychologists was not whether to underwrite the risk of those disorders or even the need for psychotherapy; rather it was a question of who they would pay for such services. The coverage remained the same.

Thus, the case at bar is similar to *Royal Drug*, where the Court held that the cost savings obtained by using specific providers, even though mentioned in the sub-

scriber contract, was not sufficiently a part of the insurer-insured relationship to be the "business of insurance" because the subscribers received the same benefit—the assurance that they could obtain drugs for a maximum payment for $2.00 on each prescription—in any event. 440 U.S. at 216-218 and n. 14, 99 S.Ct. at 1075-1976 and n. 14, 59 L.Ed.2d at 271-272 and n. 14.

III

[9] The final, critical issue is whether these combinations were "in restraint of trade." 15 U.S.C. § 1. The district court held that under the rule of reason, no violation was established. We disagree.

The district court began: "[t]he starting point in deciding the proper factual context for this case is deciding what sector of the economy is affected. . . . In other words, the court looks to see who is competing with whom." 469 F.Supp. at 560. The court found that clinical psychologists are not equal providers of therapy with psychiatrists because they do not render medical treatment and are not qualified to diagnose nervous and mental disorders or ascertain their source. The court further found that medical necessity in most, if not all cases requires regular contact between the psychologist's patient and a medical doctor.

The district court concluded that the clinical psychologist is not competitive with the psychiatrist unless the clinical psychologist is working under the "supervision" of a medical doctor. A psychologist working with a physician, the court continued, is paid by the Plans on an equal basis with a psychiatrist, except that the psychologist must bill through a physician.

The court can well understand that plaintiffs do not like to bill through a physician as a matter of pro-

> fessional pride. The evidence shows that billing through a medical doctor is a requirement of the Blue Shield plan as a means of ascertaining that the treatment given and billed for was medically necessary. This procedure also tends to promote contact between the clinical psychologists and the physicians at all stages of treatment, and thus enhances the supervisory process.

469 F.Supp. at 561.

Appellants assert that the evidence establishes a boycott and therefore their exclusion from direct Blue Shield coverage is illegal *per se*. We agree that the challenged policy closely resembles that alleged in *Ballard v. Blue Shield of Southern West Virginia*, 543 F.2d 1075 (4th Cir. 1976), which we found to be a boycott. Nor does the comparison necessarily fail because the concerted refusal to deal is conditional, rather than absolute. *See Webb v. Utah Tour Brokers Ass'n*, 568 F.2d 670, 675-76 (10th Cir. 1977); *Proctor v. State Farm Mutual Auto Ins. Co.*, 561 F.2d 262, 276 n. 23 (D.C. Cir. 1977); *Paramount Famous Lasky Corp. v. United States*, 282 U.S. 30, 51 S.Ct. 42, 75 L.Ed. 145 (1930).

The "boycott" characterization, however, avails us little in determining whether an agreement such as this is *per se* illegal. Cf. *Broadcast Music Inc. v. Columbia Broadcasting System*, 441 U.S. 1, 99 S.Ct. 1551, 60 L.Ed.2d 1 (1979). Because of the special considerations involved in the delivery of health services, we are not prepared to apply a *per se* rule of illegality to medical plans which refuse or condition payments to competing or potentially competing providers. *See Goldfarb v. Virginia State Bar*, 421 U.S. 773, 788 n. 17, 95 S.Ct. 2004, 2013 n. 17, 44 L.Ed. 2d 572; *Arizona v. Maricopa County Medical Society*, ... F.2d ....., 1980-1 Trade Cas. ¶ 63,239 (9th Cir. 1980); Note,

The Professions and Noncommercial Purposes: Applicability of Per Se Rules Under the Sherman Act, 11 U.Mich.J.L. Ref. 387 (1978).

While we agree with the district court's rejection of a *per se* rule in this case, we think the court's analysis was misdirected. The rule of reason looks to the impact of the challenged practice upon competitive conditions. *National Society of Professional Engineers v. United States,* 435 U.S. 679, 690, 98 S.Ct. 1355, 1364, 55 L.Ed.2d 637 (1979). The district court's finding that "the clinical psychologist is not competitive with the psychiatrist in treating nervous and mental disorders unless the clinical psychologist is working under the supervision of a medical doctor" reflects a value judgment, rather than an evaluation of anticompetitive effects.

The record demonstrates that psychologists and psychiatrists do complete; indeed it is susceptible to judicial notice. Both provide psychotherapy, 469 F.Supp. at 560, and are licensed to do so by State law. *See* Va.Code §§ 54-273 (10), -274, -309.1, -936 (1978 Replacement Vol.) Competition in the health care market between psychologist and M.D. providers of psychotherapy is encouraged by the legislature, see Va.Code § 38.1-824, and its existence is well documented.[11]

The Blue Shield Plans are a dominant source of health care coverage in Virginia. Their decisions as to who will be paid for psychotherapy necessarily dictate, to some extent, which practitioners will be chosen from among those competent under the law to provide such services.

---

11. One could scarcely find a more revealing statement of competitive conditions than the statement of Dr. Hulley, supra n. 6 concerning the need to stop "encroachment" by non-M.D. providers of therapy.

Whether the "medical necessity" of referral and close contact between the therapist and a physician satisfies the rule of reason, as a cost control measure, is a matter not before us. The Plan's requirement that the psychologists' fee be billed through a physician, however, cannot stand.

The issue is more than one of professional pride. State law recognizes the psychologist as an independent economic entity as it does the physician. The Blue Shield policy forces the two independent economic entities to act as one, with the necessary result of diminished competition in the health care field. The subscriber who has a need for psychotherapy must choose a psychologist who will work as an employee of a physician; a psychologist who maintains his economic independence may well lose his patient. In either case, the psychologist ceases to be a competitor.

Forewarned by the decision in *National Society of Professional Engineers, supra,* that it is not the function of a group of professionals to decide that competition is not beneficial in their line of work, we are not inclined to condone anticompetitive conduct upon an incantation of "good medical practice." Moreover, we fail to see how the policy in question fulfills that goal. Any assertion that a physician must actually *supervise* the psychologist to assure the quality of the psychotherapy treatment administered is refuted by the policy itself. The Blue Shield policy provides for payment to psychologists for psychotherapy if billed through *any* physician—not just those who regularly treat mental and nervous disorders. It defies logic to assume that the average family practitioner can supervise a licensed psychologist in psychotherapy, and there is no basis in the record for such an assumption.

There are, of course, procompetitive reasons for requiring examination and consultation by a physician in order to assure that psychotherapy is not needlessly per-

formed to treat a problem with physical etiology, but such safeguards must be accomplished in ways which do not sacrifice the economic independence of the psychologist.

The elimination of the bill-through provision does not preclude a variety of other cost control and quality control measures by Blue Shield. It does, however, expand consumer and provider alternatives. In addition, competition from licensed non-M.D. providers is likely to result in lower costs and the elimination of needless duplication of administrative costs created by the bill-through requirement.

For the reasons stated above, we affirm the judgment in favor of defendant NSV and reverse the judgment for the Blue Shield defendants. The case is remanded to the district court for appropriate relief.

AFFIRMED IN PART, VACATED AND REMANDED IN PART.

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT
No. 79-1345

Virginia Academy of Clinical Psychologists, and
Robert J. Resnick, Ph.D.,
Appellants,

versus

Blue Shield of Virginia, Blue Shield of Southwestern Virginia, and Neuropsychiatric Society of Virginia, Inc.,
Appellees.

American Psychological Association,
Amicus Curiae.
Blue Shield Association,
Amicus Curiae.
Virginia Farm Bureau Federation,
Amicus Curiae.

ORDER

(Filed September 9, 1980)

Upon consideration of the petitions for rehearing, and suggestion for rehearing en banc, by Blue Shield of Virginia, and Blue Shield of Southwestern Virginia, and a request for a poll on the suggestion for rehearing en banc was made but the poll failed for lack of majority support,

It is ADJUDGED and ORDERED that the petitions for rehearing are denied.

Entered at the direction of Judge Hall, with the concurrence of Judge Phillips and Judge Howard, U.S.D.J.

For the Court,
/s/ William K. Slate, II
Clerk

APPENDIX D

RELEVANT STATUTES

The Sherman Act: Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in relevant part as follows:

> Sec. 1 Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.

The McCarran-Ferguson Act: Sections 2 and 3(b) of the McCarran-Ferguson Act, 15 U.S.C. §§ 1012(a), (b) and 1013, provide as follows:

> Sec. 2(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.
>
> • • • •
>
> Sec. 3(b) Nothing contained in this Act shall render the said Sherman Act inapplicable to any

agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

Virginia Statutes

Va. Code § 38.1-811 (former § 32-195.2):

Medical and surgical plans.—A group of physicians may conduct through a nonstock corporation as agent for them a plan or plans for furnishing prepaid medical or surgical services, or both, and similar or related services.

Va. Code § 38.1-814 (former § 32-195.4):

Liability of participants.—All hospitals, persons, nonstock corporations and physicians participating in a plan shall be jointly and severally liable on all contracts made for the purposes of the plan by the nonstock corporation as agent for them. Each such contract executed by their agent on their behalf may be signed by the agent alone; and a contract so signed shall be binding on the principals and not on the agent. Actions for breach of such contracts may be brought against the principals by naming the agent as the sole defendant, and a judgment in favor of the plaintiff may be satisfied out of the assets of the plan in the custody of the agent or out of the assets of each and all of the principals. Each participant shall be liable for his own torts and not for the torts of any other participant or of the agent.

Va. Code § 38.1-817 (former § 32-195.5:2):

Board of directors of plan created under § 38.1-811. —Notwithstanding the provisions of § 13.1-220 of the Code of Virginia to the contrary, any plan created pursuant to § 38.1-811 shall have a board of directors consisting of not more than fifteen members; provided

that, when the geographical area to be served by a plan is increased after January one, nineteen hundred seventy-four, by the [State Corporate] Commission, the board of directors may consist of not more than twenty members. A majority of the members shall be providers of health care services.

Va. Code § 38.1-822.1 (former § 32-195.9):

Geographical area.—Every plan seeking to be licensed by the Commission shall specify the geographical area it desires to serve and shall satisfy the Commission that it is able to render the services of the plan.

The Commission may, after notice and hearing, license more than one plan for the same geographical area unless the Commission finds that (i) the plan's proposed method of operation or manner of doing business is not satisfactory or (ii) licensing more than one plan for the same geographical area will not promote the public welfare. If more than one plan is licensed in a geographical area, the plans in such area shall be obligated to make arrangements among themselves to see that any claim filed with the wrong plan in such area be promptly forwarded to the proper plan where the proper plan can be determined.

Subscription contracts shall not be sold to persons residing outside the area of the plan unless they are regularly employed within the area. The subscription contract of a subscriber who neither lives nor is employed within the area shall be cancelled by notice given in accordance with the terms of the subscription contract.

Va. Code § 38.1-824 (former § 32-195.10: 1):

Services of certain practitioners other than physicians to be covered.—No plan for furnishing prepaid medical and surgical, and similar or related services, or any of such services, shall fail or refuse, either directly or indirectly, to allow or to pay for such services, or any part thereof, rendered by any doctor of podiatry, doctor of chiropody, optometrist, optician, psychologist, or clinical social worker duly licensed to practice in Virginia, to the holder of any contract or subscription contract issued under or pursuant to such plan if the services rendered (i) are services provided for by such contract or subscription contract and, in the case of services by a clinical social worker, have been specifically contracted for by the holder of any such contract or subscription contract, which coverage must be made available to the holder of such contract, and (ii) are services which the doctor of podiatry, doctor of chiropody, optometrist, optician, psychologist, or clinical social worker is licensed to render in Virginia.

Va. Code § 38.1-347.1:

(This statute applies to commercial health insurers.)

Policy providing for reimbursement for services that may be performed by certain practitioners other than physicians.—Notwithstanding any provision of any policy of insurance, when such policy provides for reimbursement for any service which may be legally performed by a person licensed in this State for the practice of chiropractic, optometry, optician, psychology, clinical social work, podiatry or chiropody, reimbursement under such policy shall not be denied because such service is rendered by a person so licensed; provided, that the provisions of this section relating to chiropractic shall not apply to contracts issued

by plans organized pursuant to chapter 11 (§ 32-195.1 *et seq.*) of Title 32; and provided further, that the provisions of this section relating to clinical social work services shall not apply unless insurance coverage for such services has been specifically contracted for under the policy, which coverage must be made available to the purchaser of such policy. Nothing in the provisions of this section shall apply to Medicaid, or any State fund.

(Chapter 11 of Title 32, which is referenced in this statute, formerly contained the statutes governing non-profit, prepaid medical plans, such as the Richmond and Roanoke Plans. These statutes are now contained in Title 38.1.

Va. Code § 38.1-360, as amended in 1979:

Nonapplication to certain policies.—Nothing in this article shall apply to or affect (1) any policy of workmen's compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein or when issued with or supplemental to a policy of motor vehicle liability insurance, as provided for in § 38.1-21(2) to a coverage providing weekly indemnity or other specific benefits to persons who are injured and specific death benefits to dependents, beneficiaries or personal representatives of persons who are killed, provided such benefits are irrespective of legal liability of the insured or any other person, if such injury or death is caused by accident and sustained while in or upon, entering or alighting from, or through being struck by a motor vehicle; or (2) any policy or contract of reinsurance; or (3) *any blanket or group policy of insurance, except that the provisions of §§ 38.1-347.1, 38.1-348.1, 38.1-348.6, 38.1-348.7, 38.1-348.8, 38.1-348.10, 38.1-348.11 and 38.1-348.12 shall be applicable to such policies of insurance;* or (4) life in-

surance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident or as (b) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract, or (5) any policy of industrial sick benefit insurance. (Emphasis added)

NOTE: Before the 1979 amendment, Va. Code § 38.1-360 provided as follows:

Nonapplication to certain policies.—Nothing in this article shall apply to or affect (1) any policy of workmen's compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein or when issued with or supplemental to a policy of motor vehicle liability insurance, as provided for in § 38.1-21(2) to a coverage providing weekly indemnity or other specific benefits to persons who are injured and specific death benefits to dependents, beneficiaries or personal representatives of persons who are killed, provided such benefits are irrespective of legal liability of the insured or any other person, if such injury or death is caused by accident and sustained while in or upon, entering or alighting from, or through being struck by a motor vehicle; or (2) any policy or contract of reinsurance; or (3) *any blanket or group policy of insurance, except that the provisions of §§ 38.1-348.1, 38.1-348.6 and 38.1-348.7 shall be applicable to such policies of insurance;* or (4) life insurance, endowment or annuity contracts,

> or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident or as (b) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract, or (5) any policy of industrial sick benefit insurance.

(Emphasis added) Thus before the 1979 amendment, the proivsions of § 38.1-347.1, which requires commercial health insurers to reimburse psychologists, did not apply to group health insurance carried by commercial health insurers.)

APPENDIX E

(This letter was introduced into evidence at trial and appears at page 322 of the Appendix filed in the Fourth Circuit.)

BLUE CROSS
BLUE SHIELD
of Virginia

M. Roy Battista
Vice President, Provider Relations

2015 Staples Mill Road
Post Office Box 27401
Richmond, Virginia 23279
703/359-7718

May 25, 1973

TO PSYCHOLOGISTS WHOSE NAMES APPEAR ON MAILING LISTS OF BLUE SHIELD OF VIRGINIA

Gentlemen:

For some time Blue Shield of Virginia has been considering the impact of the 1973 legislative amendment to Section 32-195.10:1 of the Code of Virginia regarding payment to psychologists, optometrists and opticians. The decision has been made that Blue Shield of Virginia has considerable doubt as to the enforceability of the provision and will take appropriate legal steps to resolve this doubt and determine the enforceability of the provision as soon as possible.

Until such time as the enforceability has been determined, claims billed directly by psychologists, optometrists and opticians will be denied, but an appropriate reserve will be maintained to cover such claims if the matter is legally resolved in such a manner as to require such payment.

There will be no change in Blue Shield of Virginia's existing policy regarding the payment of claims for psychologists when billed by a physician.

Very truly yours,

BLUE SHIELD OF VIRGINIA
By /s/ M. Roy Battista

APPENDIX F

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division
(Transferred to Richmond Division)
CIVIL ACTION NO. 78-496-A

VIRGINIA ACADEMY OF CLINICAL PSYCHOLOGISTS, et al.,
Plaintiffs,

v.

BLUE SHIELD OF VIRGINIA, et al.,
Defendants.

SUPPLEMENTAL STIPULATION BETWEEN PLAINTIFFS AND DEFENDANT BLUE SHIELD OF VIRGINIA

Plaintiffs and defendant Blue Shield of Virginia ("Blue Shield") supplement their earlier stipulations as follows:

1. Beginning in the fall of 1973, attorneys from McGuire, Woods & Battle, counsel for Blue Shield, and attorneys from Mays, Valentine, Davenport & Moore, counsel for the Virginia Psychological Association ("VPA"), began discussions regarding the constitutionality of Virginia Code § 32-195.10:1. Counsel for Blue Shield and counsel for VPA expressed their respective clients' interest in obtaining a judicial determination of the constitutionality of § 32-195.10:1.

2. Counsel for Blue Shield and VPA discussed litigation between their clients to test the constitutionality of the statute and determined that a declaratory judgment proceeding in a Circuit Court pursuant to Virginia Code

§ 8-578 (now § 8.01-184) would be a suitable vehicle. It was eventually determined that the plaintiffs in such a suit should be a subscriber whose claims had been rejected by Blue Shield, and the psychologist who had rendered the subject services, together with VPA. VPA agreed to take the necessary steps to initiate the litigation.

3. Counsel for Blue Shield and VPA cooperated in ensuring that the test case was jurisdictionally proper. They were in communication, both written and oral, with one another over a period of several months, on the subject of locating a proper and willing subscriber and psychologist.

4. In late summer of 1974, VPA had obtained the necessary parties and facts to raise the legal issues. On August 16, 1974, counsel for VPA sent to counsel for Blue Shield a draft petition for declaratory judgment.

5. On December 26, 1974, a Petition for Declaratory Judgment (BSV Ex. 261) was filed in the Circuit Court of the City of Richmond, Division I, naming Mary Frances Donahoe (a Blue Shield subscriber), Theodore F. Grant (now Vice President of plaintiff Virginia Academy of Clinical Psychologists) and VPA as plaintiffs.

6. Blue Shield raised no objection it might have had to the standing of VPA as a party plaintiff.

7. Blue Shield's Answer (BSV Ex. 262) and Amended Answer (BSV Ex. 263) to the Petition for Declaratory Judgment raised the same constitutional defenses to § 32-195.10:1 that Blue Shield has raised in this action.

8. Discovery (except for depositions) was almost concluded in the *Donahoe* case when in March of 1976, plaintiffs filed a Motion for Summary Judgment (BSV Ex. 510), which was denied by Judge James E. Sheffield by letter Order dated June 24, 1976 (BSV Ex. 264).

9. Subsequently, VPA took a voluntary nonsuit, which was confirmed by Judge Sheffield's Order dated April 13, 1977 (BSV Ex. 266). McGuire, Woods & Battle, as counsel for Blue Shield, expressed disappointment over the nonsuit privately with Mr. Kay but was powerless to prevent it under Virginia law.

10. BSV Exs. 450, 452, 453, 461, 508 and 509 are true, exact and authentic copies of part of the correspondence between counsel for Blue Shield and counsel for VPA regarding matters leading to the commencement of the *Donahoe* suit.

/s/ Gilbert E Schill
Richard L. Williams
R. Gordon Smith
Gilbert E. Schill, Jr.
James H. Walsh
Patricia M. Schwarzschild
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No. 80-930

Supreme Court, U. S.
FILED
JAN 2 1981
JR., CLERK

In the Supreme Court of the United States

October Term, 1980

BLUE SHIELD OF VIRGINIA

and

BLUE SHIELD OF SOUTHWESTERN VIRGINIA,
Petitioners,

vs.

VIRGINIA ACADEMY OF CLINICAL PSYCHOLOGISTS

and

ROBERT J. RESNICK,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR
THE FOURTH CIRCUIT

SUPPLEMENT TO THE APPENDIX OF THE PETITION FOR CERTIORARI

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No. 80-930

In the Supreme Court of the United States

October Term, 1980

BLUE SHIELD OF VIRGINIA

and

BLUE SHIELD OF SOUTHWESTERN VIRGINIA,
Petitioners,

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and

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Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR
THE FOURTH CIRCUIT

SUPPLEMENT TO THE APPENDIX OF THE PETITION FOR CERTIORARI

Petitioners Blue Shield of Virginia and Blue Shield of Southwestern Virginia respectfully submit as a supplement to the appendix of their petition for certiorari the following decision of the district court (Warriner, J.) in this case dated December 2, 1980, which is referred to on page eight of the petition for certiorari. This decision was entered too late to be included in the original appendix to the petition

for certiorari. The listing required under Rule 28.1 of the Rules of the Supreme Court is included in the Petition for Writ of Certiorari at footnote 2.

Respectfully submitted,

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IN THE
UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

CIVIL ACTION NO. 78-0496-A

VIRGINIA ACADEMY OF CLINICAL
PSYCHOLOGISTS, et al.

v.

BLUE SHIELD OF VIRGINIA, et al.

MEMORANDUM AND ORDER

(Filed December 2, 1980)

This case comes before the Court on the defendants' Motion to Vacate and Dismiss. The defendants seek dismissal on the ground of mootness.

In *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), the Fourth Circuit Court, reversing this Court, held that the defendants acted in restraint of trade and thereby violated Section 1 of the Sherman Act. The evidence adduced at trial showed that the defendant Blue Shield of Virginia (the "Richmond Plan") had, since 1972, included in its contract a provision allowing payment to psychologists for covered services only when the services were provided under the supervision of a physician and were billed through that physician. The defendant Blue Shield of Southwestern Virginia (the "Roanoke Plan"), until November, 1976, also followed a policy of denying direct payments to psychologists for unsupervised services. At the time of trial, however, most Roanoke Plan contracts permitted direct payments. The Fourth Circuit held in this case that the "bill-

through" and physician supervision requirement included in Blue Shield contracts unlawfully restrained competition between clinical psychologists and psychiatrists in areas of treatment where the two professions overlap.[1] The case was accordingly remanded for this Court to fashion appropriate relief.

The defendants submit this action is rendered moot because both defendants have now altered their contracts to conform with Section 38.1-824 of the Code of Virginia, which, the defendants contend, requires direct payments to a psychologist who perform services covered by the subscription contract so long as the psychologist is licensed to perform those services in Virginia. In relevant part, Section 38.1-824 provides that:

> No plan for furnishing prepaid medical and surgical . . . services, shall fail or refuse, either directly or indirectly, to allow or to pay for such services rendered by any . . . psychologist . . . licensed to practice in Virginia . . . if the services rendered (i) are services

---

1. Though the Fourth Circuit found that medical supervision by a family practitioner over a clinical psychologist "defies logic," 624 F.2d at 485, it should be noted that there was no suggestion in this Court's opinion, 469 F.Supp. 552, that such an illogical practice was envisioned by Blue Shield in its practice or its contract. This Court's opinion attempted to make clear at pp. 560-61 that

> the only method of making sure that a physical disorder does not complicate treatment by a clinical psychologist is regular contact between the psychologist's patient and a medical doctor. Whether this be called supervision, or referral on a regular basis, the medical necessity for this practice in most, if not all cases, is undisputed.
>
> It thus appears that the clinical psychologist is not competitive with the psychiatrist in regard to the treatment of nervous and mental disorders unless the clinical psychologist is working under the supervision of a medical doctor.

The Court thus found a need for an extra measure of supervision so as to "rule out a physical cause of the nervous or mental problem." It is clear that a family practitioner is fully competent to perform this type of supervision.

> provided for by such contract . . . and (ii) are services which the . . . psychologist . . . is licensed to render in Virginia.

According to the defendants, this statute prohibits the physician supervision and bill-through provision previously included in their contracts.

Section 38.1-824 was enacted by the Virginia legislature in 1973. The Richmond Plan and the Roanoke Plan, in response to the legislation, decided to maintain their policies denying direct payments to psychologists and to challenge the constitutionality of Section 38.1-824. A test case was filed in State court for this purpose, but the action was subsequently voluntarily dismissed. Finally, in 1976, the Virginia State Corporation Commission brought an action against the Richmond Plan to compel compliance with the statute. *Commonwealth of Virginia ex rel. State Corporation Commission v. Blue Cross of Virginia,* Case No. 19829. As a defense in the State Corporation Commission proceeding, the Richmond Plan argued that Section 38.1-824 was unconstitutional. It continued to maintain its position until the matter was finally resolved by the Virginia Supreme Court in *Blue Cross of Virginia v. Commonwealth,* ..... Va. ....., 269 S.E.2d 827 (1980).

In *Blue Cross of Virginia v. Commonwealth,* the Virginia Supreme Court held that plans for furnishing prepaid medical and surgical services were required under Section 38.1-824 to make direct payments to psychologists for unsupervised services so long as the services were provided for under the relevant contract and the services were of a type which the psychologist is licensed to render in Virginia. ..... Va. at ....., 269 S.E.2d at 834-836. While the plaintiffs contend that Section 38.1-824 leaves open the possibility that psychiatrists could restrict payments to

psychologists under the guise of a judgment as to "medical necessity," it is clear from the *Blue Cross* decision that this form of indirect supervision is impermissible under the statute.

As the Virginia Supreme Court emphasized with respect to Section 38.1-824

> The focus is on *services* for medical care and the availability of such services. As a means to increase the accessibility of such services to the public, the legislature by the 1973 amendment has required defendants to recognize and pay for these *services* rendered by optometrists, opticians, and psychologists, but only if the services are provided for by the contract and if the services are those which those providers are licensed to render in Virginia.

..... Va. at ....., 269 S.E.2d at 836.

An indication of the nature of the services which a psychologist is licensed to render in Virginia is contained in Va. Code Ann. § 54-274(10). In that provision, a "clinical psychologist" is defined as "a psychologist who is competent to apply the principles and techniques of psychological evaluation and psychotherapy to individual clients for the purpose of ameliorating or attenuating problems of behavioral and/or emotional maladjustment." The Virginia Supreme Court has now established that when psychologists perform services for which they are licensed and such services are within the terms of the contract, a prepaid medical plan may not substitute its own judgment as to the "necessity" of the service rendered. In the Supreme Court's view, that judgment has been taken out of the hands of the defendants by the Virginia legislature's action in adopting Section 38.1-824.

Edwin P. Munson, Secretary and General Counsel of Blue Shield of Virginia, states in his sworn affidavit dated

5 November 1980 that, following the Virginia Supreme Court's decision on 28 August, Blue Shield has taken the following steps to comply with the Section 38.1-824:

> Psychologists claims (including both regular and Federal Employee Programs) are being processed for payment, payments are being made as result of such claims. In fact (with possible exception of some very recent claims), all claims for psychologists' services rendered since July 1, 1979, have been processed without regard to whether the services were supervised or billed by a physician.
>
> The former requirement that services of psychologists, in order to be paid, must have been supervised by and billed through a physician, has been completely eliminated, payment limitations are the same for psychologists as for physicians. All psychologists are being assigned provider numbers as claims for their services are being received.

This is a record only of the Richmond Plan's efforts to comply with the statute.

Counsel for the Roanoke Plan submits that at the time of trial, 90% of the Plan's subscriber contracts providing an outpatient mental or nervous condition coverage complied with Section 38.1-824. As of 1 January 1980, the Plan amended all remaining contracts to comply with the statute.

In the case of the Richmond Plan, significantly, the policy of denying direct payment was instituted in 1972, but the change in policy mandated by Virginia law has been made effective only on or after 1 July 1979. This is due to the Virginia Supreme Court's holding in *Blue Cross* that, as applied to the Richmond Plan, Section 38.1-824 was unconstitutional until 1 July 1979—the effective date of an

amendment to a companion statute, Section 38.1-347.1, which cured the constitutional infirmity. ..... Va. ....., 269 S.E.2d at 837-838. As noted previously, the Roanoke Plan began to make direct payments to psychologists under most of its contracts in November, 1976.

The Richmond Plan, in response to the S.C.C. order directing compliance with Section 38.1-824, is in the process of mailing notices to holders of individual and group subscriber contracts which were effective on or after 1 July 1979. A copy of the notice is a part of the record on remand. An examination of the notice reveals that, as a result of the S.C.C. order and the Supreme Court decision, the Richmond Plan added to contracts effective on or after 1 July 1979 a provision including any psychologist within the phrase "non-participating physician" or "non-participating doctor" as used in the contract. The bill-through and physician supervision provision is not specifically excised from subscriber contracts by the terms of the notice.

The plaintiffs argue as an initial matter that the Court is without authority to declare this action moot. They contend that the Fourth Circuit ruled against the defendants on the mootness issue when it remanded this action in that such disposition by the Court of Appeals precludes further inquiry or action by this Court.

The Virginia Supreme Court decision upholding Section 38.1-824 was issued while the defendants' petitions for rehearing and suggestions for rehearing *in banc* in this case were pending before the Court of Appeals. The plaintiffs state that the Fourth Circuit panel was advised of the Virginia Supreme Court decision since defense counsel submitted a copy of it to the appellate court on 29 August 1980. According to the plaintiffs, because the Court of Appeals was aware of the State Court's decision but none-

theless denied the petitions for rehearing and remanded the case, the Court of Appeals must have found that the action was not moot.

The Court finds that the plaintiffs' analysis is overly broad. The Court of Appeals, in remanding this case, did not make a specific ruling as to mootness. Remand would still be required if the Fourth Circuit panel found that some, but not all, of the plaintiffs' claims for relief were rendered moot by the subsequent action of the State Court. This Court will proceed to consider which claims for relief are now moot and which are not. The Court must do so whenever its jurisdiction is challenged on the ground of mootness and there has been no definitive ruling on the point. *See Great Western Sugar Co. v. Nelson*, 442 U.S. 92, 93-94 (1979); *United States v. Munsingwear*, 340 U.S. 36, 39 (1950).

The plaintiffs seek declaratory and injunctive relief. Certain of their claims for injunctive relief are intended to cure the past antitrust violations. Other claims for relief, however, are of a prospective nature. For example, the plaintiffs request that the Court enjoin the defendants from carrying out any plan, policy, or practice which has the purpose or effect of "diminishing competition between psychiatrists and psychologists. . . ." The plaintiffs also seek an order granting them "participating" provider status in the Blue Shield plans. As a final example, the plaintiffs request that they be granted proportionate representation on claims review committees and any advisory committees which Blue Shield may establish to formulate or review policies affecting payments for psychological services.

The issue before this Court at trial and the issue before the Fourth Circuit was whether the defendants as part of their contracts could refuse to pay for services rendered by clinical psychologists unless such services were billed

through a supervising physician. The Fourth Circuit underscored its narrow holding, for it noted in concluding its decision that "the elimination of the bill-through provision does not preclude a variety of other cost control and quality control measures by Blue Shield." 624 F.2d at 486. In determining appropriate relief, the Court will consider only what should be done to eliminate the supervision and bill-through provision and, where possible, to cure anti-competitive effects stemming from that provision.

Turning first to the plaintiffs' request for declaratory relief, the Court finds that this claim is rendered moot by the Virginia Supreme Court's decision in *Blue Cross of Virginia v. Commonwealth, supra.* Consistent with the terms of the Fourth Circuit decision, the plaintiff is entitled only to a judgment declaring that the inclusion of a supervision and bill-through provision in the defendants' contracts is an unlawful practice. However, the supervision and bill-through provision is already prohibited as a matter of State statute. The Virginia Supreme Court has so held in interpreting Section 38.1-824.

Furthermore, the defendant Richmond Plan has been ordered by the State Corporation Commission to bring its contracts into compliance with Section 38.1-824 as of 1 July 1979. The defendant Roanoke Plan, according to the record, has altered all of its contracts to comply with Section 38.1-824. Therefore, there no longer exists ". . . a substantial controversy, between the parties having adverse legal interests of sufficient immediacy and reality to warrant the issuance of a declaratory judgment." *Maryland Casualty Co. v. Pacific Coal & Oil Co.*, 312 U.S. 270, 273 (1941). The claim for declaratory relief will accordingly be dismissed.

Focusing solely on the supervision and bill-through provision, the Court also finds that the plaintiffs' claim

for prospective relief is rendered moot by the combined effect of the Virginia Supreme Court decision and the S.C.C. order. The defendants' decision to discontinue use of the supervision and bill-through provision is not "a mere voluntary cessation." *United States v. Concentrated Phosphate Export Assn., Inc.*, 393 U.S. 199, 203 (1968). The defendants are not "free to return to [their] old ways." *United States v. W. T. Grant Co.*, 345 U.S. 629, 632 (1953). They are barred by statute as interpreted by the highest court of the Commonwealth.

As discussed above, the plaintiffs also seek prospective relief above and beyond elimination of the bill-through and physician supervision provision—including a request for an injunction barring the defendants from carrying out any plan which has the purpose or effect of diminishing competition between psychiatrists and psychologists. A decree cannot be entered enjoining conduct about which there has been no complaint, however, nor may the Court enjoin all possible breaches of the law. *Hartford-Empire Co. v. United States*, 323 U.S. 386, 410 (1945); *John B. Hull, Inc. v. Waterbury Petroleum Products, Inc.*, 588 F.2d 24, 30 (2nd Cir. 1978), *cert. denied*, 440 U.S. 960 (1979).

The plaintiffs' request for sweeping changes in the status of psychologists *vis-a-vis* psychistrists in the Blue Shield plans are entirely without foundation in the Fourth Circuit opinion. Nowhere in the opinion does the Court of Appeals order a reorganization of the Blue Shield plan infrastructures. Nor is there any indication that the Fourth Circuit felt it necessary to grant psychologists proportionate representation on any Blue Shield committees to protect their interests. Use of the supervision and bill-through provision has been prohibited, and the effects of the past use of the provision can be dealt with without granting the plaintiffs "insider" status in the Blue Shield

plans. The Court will not consider any claims for prospective relief.

This case will go forward only on the plaintiffs' claims that the defendants must (1) give adequate notice that their policy of paying for psychologists' services only if those services were billed through a physician was in violation of antitrust law; and (2) accept, process, and pay for claims for services rendered by clinical psychologists subsequent to 1 January 1972 provided that such services were within the scope of the psychologists' licenses and were covered under a Blue Shield contract.

The defendants' Motion to Vacate and Dismiss is DENIED.

In accordance with the directions given by the Court at the 5 November hearing, the defendants are GRANTED 3 days from the date of this order within which to submit their pleadings in response to those portions of the plaintiffs' Motion for Entry of Decree which are still pertinent. The plaintiffs are GRANTED 5 days from the filing of the defendants' responsive pleading within which to submit a reply brief.

And it is so ORDERED.

/s/ (Illegible)
United States District Judge

Date: 2 December 1980

U.S.
FILED
JAN 10 1981
MICHAEL RODAK, JR., CLERK

No. 80-930

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

BLUE SHIELD OF VIRGINIA

and

BLUE SHIELD OF SOUTHWESTERN VIRGINIA, *Petitioners,*

v.

VIRGINIA ACADEMY OF CLINICAL PSYCHOLOGISTS

and

ROBERT J. RESNICK, *Respondents.*

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

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IN THE

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ROBERT J. RESNICK, *Respondents.*

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

BRIEF FOR RESPONDENTS IN OPPOSITION

PRELIMINARY STATEMENT

It has been long established by this Court,* as reflected in Rule 19 of its Rules, that "[a] review on writ of certiorari is not a matter of right, but of sound judicial discretion, and will be granted only where there are special and important reasons therefor."

As demonstrated in the argument below, no special reasons for review are presented in the instant Petition. The decision of the Fourth Circuit below, finding a combination of physicans to restrain competition from clinical psychologists by denying them important economic benefits, and rejecting proferred grounds of antitrust immunity for those anticompetitive practices,

* Rice v. Sioux City Memorial Park, 349 U.S. 70 (1954).

merely applies well-settled principles of antitrust law from *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975), through *National Society of Professional Engineers*, 435 U.S. 679 (1978), in a straightforward and routine fashion. Moreover, once the actual facts of the defendants' so-called "claims policy" are clarified (see Supplemental Statement of the Case, *infra*) it is clear that the physicians' boycott of other health care professionals here involved no underwriting risks and no business of insurance. Hence, this case presents no conflict with the decisions of this Court, and in fact, is in accordance with the decisions of other federal appellate courts which have recently decided similar issues.

In short, because the decision presented for review here is in agreement with sound judicial precedent in this Court and lower federal courts and because it presents no unusual or extraordinary issues of law, this Court's standards for review are not met and the Petition must be denied.

SUPPLEMENTAL STATEMENT OF THE CASE

Almost all of petitioners'[1] arguments in support of certiorari are founded upon this one central factual assertion: That in 1972, the Blue Shield plans decided to expand "insurance" benefits under their prepaid health care contracts to include payments for treatment of mental health problems by clinical psychologists, but only where the treatments were supervised and billed through a physician.

With this "premise" as their springboard, petitioners then argue, in essence, that this so-called "new"

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[1] Petitioners are Blue Shield of Virginia (the "Richmond Plan") and Blue Shield of Southwestern Virginia (the "Roanoke Plan").

claims policy "expanding" coverage constitutes the very essence of the business of insurance, thus casting the Fourth Circuit's decision in conflict with this Court's decision in *Royal Drug*. Moreover, according to petitioners, no conspiracy could exist since this expanded claims policy benefited psychologists to the detriment of physicians, and, in any event, petitioners must be immunized from antitrust liability lest physicians lose important rights of free speech guaranteed by the First Amendment.

Because this critical factual premise, so central to petitioners' arguments, is not supported by the record below, respondents are constrained to present this supplemental statement of the case.

Contrary to the repeated assertions of petitioners,[2] their refusal to pay psychologists did not represent an expansion of coverage. Since 1962 both Plans have included outpatient coverage for mental and nervous disorders and have approved and paid for psychotherapy as a treatment. Between 1962 and 1972, the Richmond Plan made direct payments to psychologists. In 1972, however, the Plan reversed its practice and refused to pay for psychologists' services unless those services were billed by physicians. This change represented a restriction imposed by the Plan on the *providers* whom it would pay for covered services. It meant that, in contrast to the previous practice, the Plan would make payments only to physicians and not to competing non-physician professionals licensed under

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[2] Petition, p.4, 10, 11, 13 and 14.

state law to provide the same services. This is documented by a Blue Shield Richmond memorandum which states:

> The Major Medical Contract provided benefits for the covered services of independently-billing Ph.D. psychologists from the inception of the Major Medical Contract in 1962 until a Corporate Claims Policy reversal on February 22, 1972. This policy (Interim 21.7 issued February 22, 1972) required that for covered services performed by these providers, supervision and billing through by a physician (M.D.) must occur in order for coverage to be provided. [J.A. 321, Appendix A]

The foregoing facts are clear from the record and have not been controverted.[3] Nonetheless, in direct conflict with the record, petitioners repeatedly make statements like the following:

> The claims policy here, however, is directly contrary to the economic interests of the physicians who, according to the Fourth Circuit, conspired in adopting the policy. In the absence of the claims policy, the Plans' contracts would not have covered the services of psychologists *at all*. If, as the Fourth Circuit found, psychologists compete with psychiatrists, then the claims policy improved the psychologists' competitive position to the disadvantage of psychiatrists and other physicians. [Petition 13-14.][4]

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[3] Appendix A; *see also*, 624 F.2d at 478; 469 F.Supp. at 556; Plaintiffs' Exhibit ("PX") 6-001; Trial transcript ("Tr.") 205; Joint Appendix in Fourth Circuit ("J.A.") 85; 321. The petition contains the first claim by the petitioners that the policy was anything other than a restriction on the choices available to subscribers as to eligible providers.

[4] Indeed even petitioners' "Questions Presented" misstate the facts. Question 2 asserts that the policy represented "an expansion

In fact, the record shows just the opposite. The exclusionary policy was designed, in the words of Levi W.Hulley, Jr., M.D., a physician who is the Richmond Plan's medical director, to stop "once and for all" the "encroachment" of non-physician providers [*i.e.*, competitors] who were "working their way into the therapy field."[5] Since the Richmond Plan and the Roanoke Plan are the dominant prepaid health care plans in Virginia, covering, within their respective service areas, over 40 percent of all potential patients, this policy had a devastating effect on competition. When they curtailed direct payment to psychologists, the Plans eliminated competition between physicians and psychologists for the largest single block of "insured" consumers in Virginia.

The nature of these particular Blue Shield Plans, and the manner in which the exclusionary policy came about, demonstrate that the Court below was not faced with "independent decisions" as to "insurance contracts." Instead, as the Fourth Circuit concluded, the policy represented a conclusion by "a group of professionals" that competition was not "beneficial in their line of work."[6]

For instance, the contracts administered by the Plans are between subscribers and "Participating physicians acting by and through" their agents, Blue Shield (PX7-001; J.A.332).[7] The Richmond Plan advertises

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of coverage to include psychologists [which] was directly contrary to the physicians' economic interests." Again, this statement is wrong, and all of petitioners' arguments based on it have no support.

[5] 624 F.2d at 481 n.6.

[6] 624 F.2d at 485.

[7] In citations to the record below, plaintiffs' trial exhibits are designated "PX-," and "J.A."

itself as "the economic arm of the medical profession" and as the "doctors' plan for doctors." The Plan says it is "sponsored by the Medical Society of Virginia," (PX9-006;J.A. 131, 133, 184; 342A), which during the period at issue here controlled selection of the Board of Directors. Thus, the Richmond Plan, controlled by a physician majority, proclaimed that its payment policies and practices were formulated and managed by physicians in conjunction with their trade associations. (PX9-006, J.A. 342A)

The evidence showed that the policy itself reflected a desire to limit competition between psychologists and Blue Shield's participating physicians. The non-payment policy was recommended by the Neuropsychiatric Society of Virginia (NSV), and it was endorsed by the Medical Society of Virginia.[8] It was a way to stop "encroachment." This fact is no better expressed than by a Blue Shield official who, in a letter to a participating physician, stated:

> I hope that you agree with your fellow physicians on the Blue Shield Board that Blue Shield should not make payment to a large variety of non-physicians who are now providing a number of services formerly provided only by physicians. (PX 24-008; J.A. 479).

In May, 1973, the Virginia legislature passed Va. Code Ann. 38.1-824 (the "Freedom of Choice" statute), which required the Plans to make direct payment to psychologists. The Richmond Plan decided to disobey

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[8] At the beginning of discussions about the policy, Dr. Levi Hulley, M.D., Blue Shield's medical director, sought to educate NSV about the "socio-economics" of medicine. (PX1-015; J.A. 302).

the statute and promptly communicated its decision to the Roanoke Plan. The Roanoke Plan reaffirmed its policy of paying only physicians. In August, 1975, at a meeting described by the Plans as a "Summit Meeting" between the Plans' officials, the noncompliance decision was confirmed. Subsequent Board minutes of the Roanoke Plan again confirmed that agreement:

> *Mr. Bushnell said the Plan was denying these claims due to an agreement with the other Blue Shield Plans operating in Virginia*, and at the directive of our Blue Shield Board until the Richmond lawsuit had been settled. (PX 3-038; J.A. 318) (emphasis added).

The Roanoke Plan, however, has never been a party to any litigation regarding the state statute, and the litigation in which the statute's constitutionality was finally adjudicated was an enforcement action brought only against Blue Shield Richmond by the State Corporation Commission in 1977. There has been no contention that the *Roanoke* Plan had to violate the law in order for the *Richmond* Plan to contest its validity.[9] The Fourth Circuit was fully supported by the record when it concluded that the Plans' refusal to comply "amounted to no more than an agreement to persist in economically restrictive commercial activity."[10]

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[9] There is no support in the record for petitioners' statement (Petition, p. 6, n. 12) that the Richmond Plan had been advised by counsel that it could not maintain a declaratory judgment action. No such advice could reasonably have been given, since Virginia's declaratory judgment statute clearly would have allowed such an action. Va. Code 8.01-184; Bd. of Supvrs. v. Rowe, 216 Va. 128, 216 S.E.2d 199 (1975); Cowardin v. Burrage, 195 Va. 54, 77 S.E.2d 428 (1953); Criterion Ins. Co. v. Grange Mutual, 210 Va. 446, 171 S.E.2d 669 (1976).

[10] 624 F.2d at 482.

The Fourth Circuit decision and opinion was unanimous, and was based upon settled antitrust principles which have been reaffirmed by this Court in a number of recent opinions, such as *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975), *National Society of Professional Engineers* v. *United States*, 435 U.S. 679 (1978), *St. Paul Fire & Marine Ins. Co.* v. *Barry*, 438 U.S. 531 (1978), and *Group Life and Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979).

Thereafter, the petitioners sought a rehearing and *en banc* consideration, describing the panel's decision as "bizarre" and in direct conflict with the decisions of this Court, particularly *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979). The petition for rehearing was denied on September 9, 1980.

While the case was on remand, these same petitioners, pointing to recent state court developments adjudicating their acts in violation of state law, moved the District Court to vacate and dismiss this case as moot even though the petitioners had only ceased to violate state law and made no suggestion that their combination in violation of the Sherman Act had come to an end.[11]

The District Court on December 2, 1980 correctly concluded that the case was not moot and that it would go forward on some issues of equitable relief even though some of the provisions respondents sought for a final decree were rejected.

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[11] The grounds for petitioners' mootness motion existed and were known to petitioners while this case was still within the jurisdiction of the Court of Appeals on petitioners' petition for rehearing. They waited, however, until the case was remanded to the District Court and then sought to "vacate" the Fourth Circuit's decision.

REASONS FOR DENYING THE WRIT

Rule 19 of the Rules of this Court provides that a writ of certiorari will not be granted in the exercise of the Court's discretion unless it is clear that the ". . . court of appeals has rendered a decision in conflict with the decision of another court of appeals on the same matter; . . . or has decided an important question of federal law which has not been, but should be, settled by this court, or has decided a federal question in a way in conflict with applicable decisions of this court; or has so far departed from the accepted and usual course of judicial proceedings . . . as to call for an exercise of this court's power of supervision."

These standards are not and cannot be met by the Petition here, for the Fourth Circuit's decision below rests on settled antitrust precedents in harmony with decisions of this Court and those of other federal courts of appeals. Petitioners' primary argument, that the Plans are entitled to the exemption of the McCarran-Ferguson Act, must fail because the Fourth Circuit's decision, far from being in conflict with this Court's recent decision in *Royal Drug*, was in fact compelled by that decision; it is likewise consistent with decisions in other circuits applying *Royal Drug*; and, in any event, McCarran-Ferguson Act protection is not available to petitioners because their conduct falls within the "boycott" exclusion to the Act.

The Fourth Circuit did not hold that the Plans were "inherent conspiracies," as asserted by petitioners. Instead, the holding is based on the particular facts of this case, which show active physician control and anti-competitive purpose. Additionally, the decision below rests upon findings of concerted action between the

Plans. Finally, the Fourth Circuit's *Noerr-Pennington* analysis was correct and, even if wrong, would not require reversal because of alternative grounds of concerted action.[12]

A. The Fourth Circuit Finding That Petitioners' Anticompetitive Conduct Was Not Within The McCarran-Ferguson Act Represented A Routine Application Of Supreme Court Decisions On "The Business Of Insurance" And "Boycott."

The Fourth Circuit's decision needs no review on its McCarran-Ferguson Act holdings. It rests squarely on *Royal Drug* and is also compelled by *St. Paul Fire & Marine Ins. Co.* v. *Barry, supra.* The Petition raises no important questions of law and there are no conflicting decisions in the circuits.

(1) *Business of Insurance.* The Petition makes two points here, but neither has merit.

First, the Petition argues that the refusal to pay psychologists constituted "the business of insurance" because it was an "underwriting decision" providing an "expansion" of coverage. This argument must fail because it is factually incorrect. Psychotherapy has been covered by both Plans since 1962, and until 1972 the

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[12] One alternative ground is the concerted action by the participating physicians in each Plan to refuse to pay psychologists. The record also reflects concerted action which was not acknowledged by the Fourth Circuit but which nonetheless would stand in the way of a reversal. For instance, the Plans joined together on various master contracts which contain the restrictive provision. While the Fourth Circuit did not find liability on the basis of this action, the record clearly shows this as concerted action under the Sherman Act.

Richmond Plan paid psychologists. There was a change in 1972, but it was not an expansion of coverage; instead Blue Shield simply eliminated payments to clinical psychologists for providing otherwise covered services. As the Fourth Circuit stated:

> Their decision regarding psychologists was not whether to underwrite the risk of those disorders or even the need for psychotherapy; rather it was a question of who they would pay for such services. The coverage remained the same. [624 F.2d at 484.]

In *Royal Drug*, this Court held that an arrangement whereby one group of providers (participating pharmacies) were entitled to reimbursement on more favorable terms than another group of providers (non-participating pharmacies) was not "business of insurance" entitled to protection under the Act.[13]

Faithfully adhering to that ruling, the Fourth Circuit here held that a similar arrangement whereby one group of providers (physicians) were entitled to reimbursement on more favorable terms than another group of providers (psychologists) was also not protected under McCarran-Ferguson.[14] Here, as in *Royal Drug*, the prac-

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[13] Lower courts have had no uncertainty about *Royal Drug* in this respect and there is no conflict or confusion in the circuits. *See* St. Bernard Hospital v. Hospital Service Association, 618 F.2d 1140 (5th Cir. 1980); National Gerimedical Hosp. v. Blue Cross of Kansas City, 479 F.Supp. 1012, 1014-1016 (W.D. Mo. 1979), *aff'd* 1980-2 Trade Cases ¶63,447 (8th Cir. 1980).

[14] 624 F.2d at 484. Although the Fourth Circuit did not reach the issue, under this Court's decision in *Royal Drug*, Virginia's Blue Shield Plans have no claim to McCarran-Ferguson Act protection at all since they do not engage in the risk-taking function of insurance companies and therefore are simply not engaged in the state-regulated "business of insurance." The Plans do not underwrite

tice at issue is related to and perhaps even was "indirectly referred to" in the Blue Shield-subscriber contract.[15] Yet in both cases the designation of eligible (or preferred) providers concerns the Plans' purchases of services from providers on behalf of the subscribers, not the underwriting of risk or the insurer-subscriber relationship.

The Petition's second point is that the discriminatory reimbursement practices are "indispensable for the reliable enforcement" of the subscriber contract since they assure that treatment rendered by psychologists to subscribers is "medically necessary." (Petition at 10-11). Like the Petition's first point, this assertion is factually unsound. The restraints at issue — the physician supervision and bill-through requirement — cannot be justified as a means to assure that treatment is "medically necessary." The Fourth Circuit was on solid ground when it stated:

> Any assertion that a physician must actually *supervise* the psychologist to assure the quality of psychotherapy treatment is refuted by the policy itself. The Blue Shield policy provides for payment

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risks but instead contract to provide health care services to their subscribers *in kind* upon need. In fact, the Plans admit they are immune from risk altogether since their participating physicians have agreed in advance to provide all required services to subscribers in return for whatever money is available through the Plans. (Tr. 932; J.A. 203.) Also, the Plans are excluded from the application of key provisions of the state insurance code. In particular, while insurance company rate-making is regulated (the key reason for the McCarran-Ferguson Act exemption), Blue Shield premium-fixing is not. *Compare* Va. Code §38.1-241 (1976) with §38.1-818 (Supp. 1979) (Tr. 607, 620-21; 355; J.A. 113; 155-157.)

[15] *See Royal Drug, supra*, 440 U.S. at 216 n. 14.

> to psychologists for psychotherapy if billed through any physician — not just those who regularly treat mental and nervous disorders. It defies logic to assume that the average family practitioner can supervise a licensed psychologist in psychotherapy, and there is no basis in the record for such an assumption. [624 F.2d at 485]

Petitioners' argument that the bill through requirement is necessary for "reliable enforcement" is really just an echo of the "incantation of 'good medical practice' " which the Fourth Circuit properly rejected as a justification for the Plans' anticompetitive behavior under this Court's decision in *National Society of Professional Engineers* v. *United States*, 435 U.S. 679 (1978). 624 F.2d at 485. The Court's decision there — that groups of professionals may not impose curbs upon competition for reasons of public welfare — applies with even greater force here, where the policies of the Sherman Act are joined with a state legislative determination that the public welfare requires psychologists to be free to compete as independent economic entities with physicians.[16]

The Petition's second point is defeated also by another important teaching of *Royal Drug* — that the McCarran-Ferguson Act must be read narrowly, particularly when Blue Shield plans are involved. The Court made it clear that concepts of "reliability, interpretation and enforcement" cannot be used to expand the scope of the McCarran-Ferguson Act.[17]

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[16] It would be particularly ironic if the conduct of the Blue Shield Plans here, which violates state law, were to be immunized from antitrust scrutiny by the McCarran-Ferguson Act, which was itself inspired by a policy of deference to state regulation.

[17] 440 U.S. at 217-232.

(2) *Boycott*. Even if the Court granted review here, and decided that the Fourth Circuit's analysis of *Royal Drug* was wrong, the decision below would still be left standing because, as a "boycott," the petitioners' conduct falls outside the area of McCarran-Ferguson Act protection. As the Fourth Circuit observed,[18] the Plans' reimbursement practices with respect to psychologists in this case closely resemble the practices with respect to chiropractors in *Ballard* v. *Blue Shield of Southern West Virginia*, 543 F.2d 1075 (4th Cir. 1976), *cert. denied*, 430 U.S. 922 (1977), where a similar boycott determination was made by the same Court. In view of *St. Paul Fire & Marine Ins. Co.* v. *Barry, supra*, that conclusion is both correct and unremarkable.

B. The Fourth Circuit Did Not Find All Blue Shield Plans To Be "Inherent Conspiracies" And Its Decision, Compelled By The Particular Facts Of This Case, Does Not Threaten The Existence Of Any Blue Shield Plan.

The Petition is factually wrong when it asserts that the Fourth Circuit's finding of concerted action was predicated on the physician majority on the Richmond Plan's Board of Directors. (Petition 12) This is not just a "structural" decision; active anticompetitive conduct was proven. When more objectively examined, the Fourth Circuit decision will be seen as it is — an application of

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[18] Petitioners erroneously assert that the Fourth Circuit did not reach the question whether these practices are a boycott. (Petition at 7 n.17.) While the Fourth Circuit did decline to apply a *per se* analysis because "of the special considerations involved in the delivery of health services," the practices at issue were nonetheless found to constitute a boycott, and to be an unreasonable restraint of trade. 624 F.2d at 484-85.

familiar antitrust principles to group action with unquestionably anticompetitive purpose and effect.

As set forth earlier,[19] the Richmond Plan acted as agent for its physicians; it called itself the "doctors' plan for doctors;" it said it was sponsored by the Medical Society of Virginia and was the "economic arm of the medical profession;" and its payment practices were openly formulated by physicians in conjunction with their trade associations. The practice at issue here eliminated competition between participating physicians and their non-physician competitors for the business of servicing the largest single block of Virginia consumers. This elimination of competition was no accident; in the words of Blue Shield's medical director it was designed "once and for all" to stop "encroachment" by non-physicians into the province of medical doctors. The restrictive policy was recommended, formulated and adopted by Blue Shield's physician board members,[20] and it directly benefited their own economic interests.

The Petition rests heavily on an effort to distinguish *United States* v. *Sealy, Inc.*,[21] but this effort must fail

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[19] *See* pages 5-6, *supra*.

[20] The non-medical staff of the Richmond Plans had commenced plans to comply with the Freedom of Choice law, but those plans were terminated by a decision of the physician-dominated Blue Shield board. *E.g.*, PX 3-004; J.A. 311. That decision was not based on factors of public health or cost, because those factors were not considered at the time. What was considered was the idea that the legislature should not "mandate" or "dictate" that nonphysicians should be paid by the "doctors' plan for doctors." Tr. 576.

[21] 388 U.S. 350 (1967).

because it relies on two factual errors. First, as seen above, the Fourth Circuit did not find concerted action based simply on the composition of the Plans' boards of directors. Second, and just as important, the Fourth Circuit recognized, as did this Court in *Sealy*, the significance of the fact that the practice in question promoted the economic and competitive interests of the decisionmakers; *i.e.*, the licensees in *Sealy* and the physicians here. When the petitioners assert that the practice here — the refusal to pay psychologists — is contrary to the interests of participating physicians (Petition 13), they ignore and seek to obscure the fact that the practice was a restriction designed to stop non-physician "encroachment."

The Fourth Circuit correctly determined that the Plans were not acting here as unitary entities, and that they did not reach independent business judgment apart from the collective will of their participating physicians. This is not a remarkable conclusion; the Supreme Court of Virginia reached the same result when it examined the counterpart Blue Cross organization ten years ago.[22]

In complete disregard for the record, petitioners claim that each Plan is "indistinguishable from an ordinary, widely-held corporation" and cite the "black letter rule that a corporation cannot conspire with itself." (Petition 13) The Plans are not public stock corporations but rather are membership associations and this Court

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[22] Blue Cross of Virginia v. Commonwealth, 211 Va. 180, 176 S.E.2d 439, 435 (1970). There, among several combinations found to violate the Sherman Act "was that of the participating hospitals which constitute Blue Cross, in the same fashion as participating physicians constitute Blue Shield." 624 F.2d at 480. *Compare* Va. Code §38.1-810 with §38.1-811.

has repeatedly rejected such defenses where professional associations have placed restraints on competition to the benefit of their members. The Fourth Circuit properly and explicitly relied on that authority in rejecting those arguments here. *See* 624 F.2d at 481, *citing, e.g., National Society of Professional Engineers* v. *United States, supra*, (association's policy of prohibiting competitive bidding among members struck down as conspiracy among members of the society to restrain trade); *Goldfarb* v. *Virginia State Bar, supra*, (minimum fee schedule for county and state bar associations struck down as price fixing between the associations and their members); *Silver* v. *New York Stock Exchange*, 373 U.S. 341 (1963) (association of member stock brokers held to have conspired in violation of the Sherman Act by withdrawing rights to instant electronic access to stock quotes from non-member brokers, thus depriving them of substantial business benefit); *Radiant Burners, Inc.* v. *Peoples Gas Light Coke Co.*, 364 U.S. 656 (1961) (trade association held to have violated Sherman Act by discriminatorily refusing to certify as safe a non-member's gas burner); *Fashion Originators Guild* v. *Federal Trade Commission*, 312 U.S. 427 (1941). *See also, Associated Press* v. *United States*, 326 U.S. 1 (1945).

The teaching of these cases — which is not new, novel or cause for confusion or uncertainty — is that trade associations and professional organizations risk antitrust liability when they restrict competition among members or when they assist the economic interests of their constituents to the detriment of other, excluded, competitors. They become vulnerable to attack whenever they withhold "[a] valuable service germane to [industry members'] business and important to their economic

competition with others," for arbitrary, capricious or anticompetitive reasons. *Silver, supra*, 373 U.S. at 348 n.5. Blue Shields' participating physicians control a truly "valuable business service" which all health care professionals need "in order to compete effectively" in the marketplace. *Silver, supra*, 373 U.S. at 347. Forty percent of Virginia health care consumers are entitled to Blue Shield benefits and any competitor for these consumers whose services are not covered by Blue Shield is effectively excluded from this market.

The Fourth Circuit decision in no manner threatens a Plan's ability to make "routine decisions . . . regarding coverage," as petitioners allege.[23] (Petition 14). The Fourth Circuit's opinion expressly provides that the Plans are free to chart their own courses with respect to coverage and other matters germane to their operation, so long as their actions do not unreasonably restrict competition between physicians and other health care providers qualified to provide the services which the Plans have decided to include within the coverage of their subscriber contracts. The line between legal and illegal conduct has been clearly drawn, *e.g., National Society of Professional Engineers, supra*, and there is nothing unsettling or extraordinary about the Fourth Circuit opinion on this issue.

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[23] Indeed, other district courts in the Fourth Circuit have since rejected such an *in terrorem* construction, concluding that it was the physician dominance and anti-competitive purposes which controlled. Human Resources Institute of Norfolk v. Blue Cross of Va., 498 F.Supp. 63, 66 (E.D. Va. 1980) ("*VACP* does not stand for the proposition that an agency relationship, or a 'collective nature,' can, without more, bring a prepaid health plan within the purview of the Sherman Act. Rather . . . it was the abundant evidence of physician control [which established a violation].")

C. The Fourth Circuit Correctly Held That The Plans' Joint Action to Exclude Psychologists Is Not Protected Speech Under the Noerr-Pennington Doctrine.

Recognizing that immunities for antitrust violations are to be narrowly construed, federal courts have been careful to limit the scope of *Noerr-Pennington* immunity to activities necessary to produce desired legislative or judicial action and not to collateral commercial practices which have anticompetitive consequences. "[O]ne does not escape Sherman Act proscriptions by camouflaging true antitrust violations with the plumage of 'political activity.'" *Cow Palace, Ltd.* v. *Associated Milk Producers, Inc.*, 390 F.Supp. 696, 702 (D. Colo. 1975). The *Noerr-Pennington* doctrine certainly protects the First Amendment right to petition, but it does not sanction anticompetitive conduct which is not necessary in the exercise of that right.

Petitioners overlook this crucial distinction in arguing that the *Noerr-Pennington* doctrine immunizes their activity. They appear to concede, as they must, that the Plans agreed with each other that both Plans would refuse to pay psychologists, in violation of the state statute. Their argument, however, is that the Plans somehow insulated this anticompetitive conduct from review under the antitrust laws *by also having* discussions about a challenge to the validity of the state statute. This argument must fail since the Roanoke Plan admittedly never challenged the statute, 624 F.2d at 482; there is thus no *Noerr-Pennington* justification for *Roanoke's* collaboration in *Richmond's* violation and that collaboration in no way affected any exercise of First Amendment rights.

Moreover, as the Fourth Circuit reasoned, any challenge to the validity of the "Freedom of Choice" statute could have been mounted by either or both Plans without any agreement between them to flout the law and engage in anticompetitive activity in the process.[24] Indeed, there is no way in which the joint *conduct* of the Plans in violating the statute can have been calculated to advance any petition by either or both for legal redress. Since it was not necessary to violate the law in order to test it, the Plans have no claim whatever to *Noerr-Pennington* protection.

In an effort to create a reviewable issue where none exists, petitioners cite a number of cases involving economic boycotts by groups which had purely political objectives, and no anticompetitive motives. These cases are instructive, if at all, for the stark contrast they pre-

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[24] 624 F.2d at 482. Va. Code §8.01-184 permits state courts to determine the constitutionality of a statute whenever the petitioner is presently affected by its operation. *See e.g.*, Bd. of Supvrs. v. Rowe, 216 Va. 128, 216 S.E. 2d 199 (1975); Cowardin v. Burrage, 195 Va. 54, 77 S.E.2d 428 (1953); *See also* Criterion Ins. Co. v. Grange Mutual, 210 Va. 446, 449 171 S.E. 2d 669 (1976); Patterson v. Patterson, 44 Va. 113, 131 S.E. 217, 219 (1921). A declaratory action — in state or federal court — challenging the constitutionality of the law could have been maintained by either or both of the Plans had they chosen to press their arguments in an affirmative fashion.

Alternatively, one Plan or the other could have submitted a noncomplying contract to the State Corporation Commission for rejection — which is how the issue was in fact ultimately raised, although the Richmond Plan was drawn quite unwillingly into the proceedings. Commonwealth of Virginia ex rel. State Corporation Commission v. Blue Cross, et al., Case No. 19829 (PX 14-001; 002; J.A. 358,359).

sent to this case. In each case cited,[25] the boycott was motivated entirely by a desire to advance some political goal. The boycotts were wholly devoid of anticompetitive purpose. In fact, the boycotts were clearly adverse to the economic interests of the boycotting parties. In each case, the boycott represented a dramatic and highly visible means of *communicating* to the public for the purpose of obtaining political action. Further, in each case, the boycott was reasonably believed to be the only effective way to communicate political views, and, having communication as a purpose, the boycotts were short in duration.

By contrast, this case differs on all points. The Plans' boycott is directed against psychologists, a nonphysician provider group which competes in the provision of services with the Plans' own physician members. The objective of the boycott is not to exert influence on, or obtain access to, the courts or agencies, but rather to curtail "encroachment" of psychologists. There is no nexus between the Plans' refusal to reimburse nonphysician providers, and any challenge to the validity of the "Freedom of Choice" statute. The Roanoke Plan never challenged the statute; and its agreement not to comply furthered no protected goal. In fact, neither Plan had to violate the law in order to contest it. Also, there was no element of communication involved, and the boycott was in place for over seven years. As the Fourth Circuit held, the Plans' refusal to reimburse "amounted

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[25] Missouri v. National Organization of Women, Inc. 620 F.2d 1301 (8th Cir. 1980), *cert. denied*, _____ U.S. _____, 49 U.S.L.W. 3216 (October 6, 1980); Crown Central Petroleum Corp. v. Waldman, 486 F.Supp. 759, 766-68 (M.D. Pa.), *rev'd. on other grounds*, 1980-2 Trade Cases ¶63,635 (3d Cir. Nov. 17, 1980); Allied International, Inc. v. International Longshoremen's Ass'n., 492 F.Supp. 344 (D. Mass. 1980).

to no more than an agreement to persist in economically restrictive commercial activity in the face of a State law designed to open up the health care market."[26]

Other courts have recognized in similar cases that the *Noerr-Pennington* doctrine protects only "speech" within usual First Amendment meanings, and that it does not extend to the "non-speech" aspects of concerted activity. Thus, the Eighth Circuit, in an opinion citing its earlier decision in *Missouri* v. *National Organization of Women, supra*, held that conduct otherwise illegal cannot be immunized merely because it is carried out by means of speech. *International Travel Arrangers, Inc.* v. *Western Airlines, Inc.*, 623 F.2d 1255, 1267 n.14 (8th Cir. 1980). There, an ad campaign by an airline company which was part and parcel of an effort to stifle competition from a chartered flight firm was found to be an unreasonable restraint of trade. And in *United States* v. *Southern Motor Carriers Rate Conference, Inc.*, 467 F.Supp. 471 (N.D. Ga. 1979), an association of truckers was held to have violated the Sherman Act when its members fixed prices, submitted the fixed prices to state regulatory bodies for approval, and then implemented those prices. The court held that Congress, under the Sherman Act, can legitimately reach the "independently cognizable acts" of price fixing even though they were taken in connection with a petition to influence state actions. *Id.* at 485; *cf. Teamsters Local 695* v. *Vogt*, 354 U.S. 284 (1957) (state may prohibit picketing directed at achieving a union shop in violation of state law). As in the *Southern Motor Carriers* rate case, the concerted actions of the Blue Shield Plans to refuse to deal directly with clinical psychologists are not

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[26] 624 F.2d at 482.

an exercise of free speech, symbolic or otherwise, but rather "constitute independently cognizable acts outside the scope of First Amendment protection or the *Noerr-Pennington* doctrine." 467 F.Supp. at 485.[27]

In sum, the Fourth Circuit reached the inescapable conclusion that the agreement of the Richmond and Roanoke Plans to boycott clinical psychologists was mere commercial activity, not entitled to the protection reserved for activities aimed at the passage, enforcement or rejection of state law. The Petition does not present a genuine issue worthy of review.

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[27] The sham exception to the Noerr-Pennington doctrine was not relied upon by the Fourth Circuit in this case because the protection of the doctrine never arose with respect to the Plans' purely commercial (and otherwise illegal) activity.

Conclusion

The Fourth Circuit opinion is clearly correct in its analysis and result, and does not raise questions for which Supreme Court review is necessary or appropriate. The Fourth Circuit opinion represents an unexceptional application of familiar, well-established and long acknowledged antitrust principles. The Blue Shield Plans cannot claim surprise, for in all respects, the Fourth Circuit opinion simply concurs with earlier decisions by this Court, other federal courts and the Virginia Supreme Court. Accordingly, the Petition must be dismissed.

Respectfully submitted,

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APPENDIX

APPENDIX A

(This Letter Was Introduced Into Evidence At Trial And Appears At Page 321 Of The Appendix Filed In The Fourth Circuit)

INTER-OFFICE COMMUNICATION

BLUE CROSS
BLUE SHIELD
of Virginia

To: Mr. Langhorne H. Smith

Date: March 23, 1976

From: Richard V. Morrow

Subject: PSYCHOLOGISTS' SERVICES PERFORMED BY PH.D. PSYCHOLOGISTS

In answer to your memorandum of March 22, 1976, the following are guidelines which have been utilized in the Major Medical Claims area in the adjudication of psychologists' services performed by Ph.D. psychologists.

The Major Medical Contract provided benefits for the covered services of independently-billing Ph.D. psychologists from the inception of the Major Medical Contract in 1962 until a Corporate Claims Policy reversal on February 22, 1972. This policy (Interim 21.7 issued February 22, 1972) required that for covered services performed by these providers, supervision and billing through by a physician (M.D.) must occur in order for coverage to be provided.

The above referenced Corporate Claims Policy (Interim 21.7), as previously stated, was implemented on February 22, 1972 and became a permanent policy on May 27, 1975.

From the time we began paying for these services in 1962, we were not aware that the psychologists had to be licensed until some time in 1971. Therefore, from 1962 until 1971 the services of an independently-billing psychologist, whether or not licensed, were covered; and from 1971 until February 22, 1972 we required licensing of the psychologist before services could be provided.

The contracts, to my knowledge, had no significant changes or differences during this entire period of time.

No. 80-930

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

BLUE SHIELD OF VIRGINIA

and

BLUE SHIELD OF SOUTHWESTERN VIRGINIA,

Petitioners,

vs.

VIRGINIA ACADEMY OF CLINICAL PSYCHOLOGISTS

and

ROBERT J. RESNICK,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR
THE FOURTH CIRCUIT

REPLY BRIEF OF PETITIONERS

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ON PETITION FOR WRIT OF CERTIORARI TO THE
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REPLY BRIEF OF PETITIONERS

Pursuant to Rule 22.5 of the Rules of the Supreme Court, Petitioners respectfully submit this reply brief in support of their Petition for Writ of Certiorari. The listing required under Rule 28.1 of the Rules of the Supreme Court is included in the Petition for Writ of Certiorari at footnote 2.

(A) The Claims Policy Was an Expansion of Coverage Under the Plans' Contracts with Their Subscribers

In its brief in opposition, VACP argues that the claims policy adopted by the Richmond Plan in 1972 "did not represent an expansion of coverage," because, according to VACP, the policy of the Richmond Plan even before 1972 was to pay psychologists directly for services to its subscribers.[1] VACP is mistaken. The district court found as follows:

> [The Richmond Plan] had been inconsistent in its policy during the 1960's and early 1970's in regard to payment of clinical psychologists. There is evidence that clinical psychologists had been paid for services independently rendered and yet it is not clear that this was company policy. *Instead it appears that it resulted from a lack of company policy.*[2]

Thus, before 1972 the Richmond Plan had no policy regarding payments to psychologists and certainly no policy to pay psychologists for services to subscribers. The Fourth Circuit did not disturb this finding of fact.

Before 1972 the contract between the Richmond Plan and its subscribers by its terms *did not cover* services rendered by psychologists. The contract covered only "medically necessary services . . . performed or prescribed by a Physician."[3] Since psychologists are not physicians, treat-

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[1]Brief in opposition at 3.

[2]469 F. Supp. at 558 (Appendix at A13-14) (emphasis added). The memorandum from the record in this case that VACP attached to its brief in opposition as Appendix A was written four years after the claims policy was adopted and is flatly contrary to the factual finding of the district court quoted above, which was made on the basis of the record taken as a whole.

[3]Richmond Plan Exhibit 296 (Group Major Medical Service Certificate -A)

ment by psychologists was outside the coverage of the Richmond Plan's contract. The adoption of the claims policy in 1972 meant that the Richmond Plan would pay for psychologists' services under its contract. This was an expansion of the services covered by the contract as well as an increase in the risks accepted by the Richmond Plan.

VACP's argument that the claims policy is not an expansion of coverage does not even apply to the Roanoke Plan. From 1945 when the Roanoke Plan was organized until at least 1974 the Roanoke Plan's contract covered only medical services performed by a physician, and therefore did not cover psychologists' services. However, since 1945 the Roanoke Plan has paid for psychologists' services where a physician refers the patient to the psychologist, supervises the treatment and submits the bill to the Plan. Thus, the Roanoke Plan never paid psychologists directly, and VACP's argument that the claims policy was not an expansion of coverage does not reach the Roanoke Plan.

(B) The Fourth Circuit Did Not Reach the Question Whether the Claims Policy Was a Boycott Within the Meaning of McCarran-Ferguson Act

VACP contends that the judgment below would be unchanged even if this Court holds that the claims policy is part of "the business of insurance" within the meaning of the McCarran-Ferguson Act because the Fourth Circuit allegedly found the claims policy to be a "boycott" outside the scope of McCarran-Ferguson protection.[4]

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[4]Brief in opposition at n. 18.

Again VACP is clearly in error. The Fourth Circuit did not hold that the claims policy was a boycott in the context of the McCarran-Ferguson Act.[5] For this reason, a reversal by this Court of the Fourth Circuit's holding that the claims policy is not "the business of insurance" would reverse the judgment below.

(C) The Plans' Good Faith Exercise of Civil Rights Guaranteed by the First Amendment is Fully Protected by the Noerr-Pennington Doctrine

In this case the Plans exercised their civil rights under the First Amendment by refusing to obey a state statute that they believed — correctly — to be unconstitutional. The Plans acted openly and in good faith.[6] Their purpose in refusing to obey the statute, as confirmed by the Fourth Circuit, was "to provoke a judicial resolution" of the statute's validity.

VACP seeks to distinguish the cases cited by the Plans by claiming that the actions of the defendants in those cases were "motivated entirely by a desire to advance some political goal" as opposed to the allegedly anticompetitive objectives of the Plans' civil disobedience.[7] The *Noerr-Pennington* doctrine draws no such distinction. Indeed, in *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*[8] this Court acknowledged that the "sole

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[5]624 F.2d at 483 (Appendix at A43). Furthermore, in its discussion of the restraint of trade issue the Fourth Circuit did not expressly find the claims policy to be a boycott. 624 F.2d at 484 (Appendix at A46).

[6]*See* Petition for Writ of Certiorari at 15 and in particular the stipulation between counsel attached to the Writ of Certiorari as Appendix F.

[7]Brief in opposition at 21.

[8]365 U.S. 127, 138-139 (1961).

purpose" of defendants' lobbying efforts was to destroy competition from truck freight carriers. Accordingly, even if the Plans' interests in disobeying the Virginia direct payment statute had not been wholly political, their open and good faith[9] — and ultimately successful — attempt to "provoke a judicial resolution" of the statute's unconstitutionality is clearly First Amendment activity that falls within the *Noerr-Pennington* doctrine.

Respectfully submitted,

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[9]Contrary to VACP's suggestion, brief in opposition at n. 27, the Fourth Circuit unequivocally held that the Plans' conduct was not within the "sham" exception to the *Noerr-Pennington* doctrine. 624 F.2d at 482 n. 9 (Appendix at A41).